JULY • AUGUST 1965

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Adolescence and Its Problems

Refocusing Psychiatric Services

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National Day Care Conference

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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VOLUME 12
NUMBER 4
JULY–AUGUST 1965

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AN ADOLESCENT in communion with a book. Even in such quiet moments, adolescents live in a world that is typically more tumultuous, more subject to fluctuating moods, and in general more "difficult" than the world of the child, which they are leaving, or the world of the adult, which they have not yet entered. The articles beginning on page 131 and page 136 throw revealing light on the adolescent's world.

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Evidence of a growing realization that the problems troubling young people in the critical period between childhood and adulthood require special attention, both for their own and society's sake, prompts CHILDREN to present the following two articles on adolescence. The first, based on a working paper prepared for the World Health Organization's Expert Committee on the Health Problems of Adolescence, outlines the interacting biological, psychological, and social influences which affect the developmental process in this stage of life. The second, beginning on page 136, while derived from a psychiatrist's practice, has pertinence for any professional person intent on helping adolescents deal with their problems.

A DEVELOPMENTAL APPROACH TO ADOLESCENCE

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ADOLESCENCE may be defined as a critical period of human development manifested at the biological, psychological, and social levels of integration, of variable onset and duration but marking the end of childhood and setting the foundation for maturity. Biologically, its onset is signaled by the acceleration of physiological growth and the beginnings of secondary sexual development, its termination by the fusion of the epiphyses of the bones and the completion of sexual maturation. Psychologically, it is marked by an acceleration of cognitive growth and of personality formation, both of which continue to be subject to further evolution, though at a less marked rate, in subsequent stages of adulthood. Socially, it is a period of intensified preparation for the assumption of an adult role, and its termination is signaled when the individual is accorded full adult prerogatives, the timing and nature of which vary widely from society to society.

Adolescence is a "critical period" in development in being both a time of rapid and profound change in the organism and a time providing the necessary—but not sufficient—conditions for full maturation in adulthood. Optimal development in adolescence depends on successful accomplishment of the developmental tasks in infancy and childhood. Thus, clinical experience has indicated that adolescence is likely to be particularly stormy, prolonged, and sometimes poorly resolved if it follows a childhood marked by severe deficits.

Whether or not appropriate "experiential supplements" during adolescence can lead to successful negotiation of this period despite pathology in earlier life is not known. The heuristic hypothesis is to assume that repair can occur and that the task of the physician is to search for ways of encouraging optimal growth during the adolescence of a previously damaged child.

Although a rich, fulfilling adolescence provides the best groundwork for a successful adulthood, such an outcome is not automatic; it depends, in turn, on the provision of opportunities during adulthood for

the creative exercise of the abilities achieved in adolescence.

The structural groundwork for adolescent development is laid by physical maturation. This developmental sequence is not preformed or automatic but depends upon an interaction between biological capacity and environmental stimulation. Just as growth requires adequate nutrition—being subject to delay or even cessation in the presence of starvation and to acceleration in the presence of optimal intake—so psychological maturation is dependent upon "psychological nutrition," that is, sequential opportunities for cognitive and social stimulation so timed that they promote further mental development.

Interdependent Developments

Thus, adolescence is simultaneously a biological, a social, and a psychological phenomenon. Development at each of these levels of integration proceeds not independently but with significant interaction, with events at any one level able to impede or to accelerate developments at each of the others.

For example, although the time at which the hypothalamic-pituitary axis initiates the biological sequence of adolescent growth is a function of individual heredity, it may, in a given individual, be delayed or advanced by environmental factors. Thus, the ultimate height attained by adolescents in economically developing countries has shown striking gains as nutrition has improved. Similarly, the time of menarche has shown a trend toward acceleration in countries in which increasingly better health of the children has been achieved. These physiological trends are the result of industrial and social organization.

Or again, biological maturation provides the increasing muscular strength and dexterity which permit the adolescent to participate successfully in the activities of his social group, thus acquiring a psychological sense of adequacy. At the same time, positive psychological motivation is a prerequisite for task perseverance and the search for variety of experience, which provide the conditions necessary for full muscular development through exercise.

Developments at the biological and psychological levels occur in a social framework, which may promote or retard them. Thus, unscientific notions about diet prevalent in a specific culture may lead to inadequate nutritional intake, and social prejudices against minority group members may deprive them of experiences necessary for full development.

The importance of such reciprocal influences is underscored by the fact that each society is dependent upon its adolescents as its future adults. Failure to provide them with the conditions necessary for optimal development will severely handicap the growth potential of that society.

Biological adolescence has fairly precise signs of its onset and termination, such as growth acceleration, sexual development, and epiphyseal fusion, but there is remarkable variation in the timing of their appearance in different individuals. Onset in normal children may occur as early as age 7 or 8 or as late as 17 or 18; termination as early as 15 or 16 or as late as 24 or 25. The timing seems to be a function both of internal factors, such as sex and inheritance, and external factors, such as nutrition or illness. In other words, the biological factors set wide limits for the onset, termination, and achievements of adolescence, the potential limits being subject to modification by environmental influences, among which both psychological and social factors play a role.

Social Preparation

Adolescence as a social phenomenon, though restricted in range by biological considerations, is a function of cultural norms. In general, the more sophisticated the society is in its technology, the more prolonged is adolescence, since the complexity of the preparation required for the assumption of adult roles depends upon the demands the society sets. In the United States, for example, the long period of study required for specialized occupational roles delays the age of self-support, the opportunity for marriage, and the age of creative contribution to society—all attributes of the adult role.

In many cultures, the onset of adolescence is clearly signaled by puberty rites, usually in the form of tests of strength and courage, the completion of which entitles the individual to recognition as a young adult. In technologically advanced societies, such clear signification of the end of childhood is absent and the requirements for adulthood less clearly defined: the individual must, therefore, undergo a more prolonged and, at times, confused struggle to attain adult status.

Each culture provides experience specifically designated as part of the training of the adolescent, such as schooling and apprenticeship; other experiences, such as dating and courtship, which are for the most part limited to adolescence but are not formally organized; and other non-age-related opportunities for personal development which may be particularly

meaningful for the adolescent, such as opportunities to participate in cultural and political life.

Deliberate social planning based on a scientific analysis of adolescents' needs has been relatively neglected, the forms and structures society provides having evolved empirically. Only within school systems has such planning been explicit, but even there with little careful research. Yet careful assessment of the needs of adolescents at all levels of developmental integration could lead to the design and provision of external conditions that would greatly accelerate the rate, and markedly increase the ultimate level, of the development of the human adolescent's full potentialities.

The Idealism of Adolescence

At a psychological level, the most striking attainment during adolescence is the ability to conceptualize at an abstract level. The further evolution of what Piaget calls the "concrete operations" of childhood [1] through interaction with increasingly more demanding intellectual tasks, provided both by formal schooling and informal social experience, leads to the ability to "think about thinking" and to analyze problems at a high level of generalization. It is here that the *Anlage* of scientific thought and creativity is to be found. This evolution of intellectual function requires appropriate environmental stimulation.

The adolescent's capacity for abstract thought accounts for his increasing concern with, on the one hand, national and international problems and, on the other, with the basic meanings and values of human existence. This "idealism" of adolescence is, of course, shaped by the cultural envelope which surrounds the individual, but its very existence leads to questioning, to examination of basic premises, and to dissatisfaction with the imperfections in the world adults have created. Its cultivation may be regarded as one of the most important tasks of society.

Fostering and strengthening this "suprapersonal" psychological trait in adolescents will lead to the creation of adults who will in turn enhance the society that bred them. The lack of adequate opportunity for its positive expression will warp the adolescent's normal development and lead to a generation of self-preoccupied adults who will fail to meet the challenge of history.

Personal Identity

A second and related psychological theme of adolescence is the search for a sense of personal identity, to employ the terminology of Erikson.[2] No longer a child and not yet an adult, the adolescent is busily engaged in determining who he is and what he is to become.

In this effort, he examines his parents from a more critical perspective and leans more to peer groups for his sense of belonging. If his relations with his parents have been soundly constructed during earlier years, and if they meet his doubts and criticisms with sympathetic understanding, this temporary unsettling of his prior role as a child leads to a resynthesis of his relations with them on a firm and lasting basis, one marked by reciprocal respect and by personal independence without abandonment of filial loyalty. Where the parent-child relationship has been one of excessive dependence or excessive hostility, the turmoil of adolescence may be prolonged and lead either to failure of emancipation or to rejection of family ties and a lasting sense of isolation.

Sexual Role

A third key developmental task consists of the further evolution of sexual identity and role-appropriate behavior. Learning the social role of one's sex is firmly rooted in childhood—in culturally differentiated role assignments, in emulation of the like-sexed parent, and in peer interactions. These experiences provide a constant feedback, both by comparison of the self with others and by praise or blame from them, which informs the child as to what sex he is and what kind of behavior expectations this entails. These preliminary psychological structures are challenged by the adolescent's consciousness of his development of adult sexual characteristics and his experience of a bewildering array of new physical sensations, both of which lead to an upsurge of interest in physical sex and a psychological sensitization to a new aspect of interpersonal relationships. The forces in the social field then determine the further steps in his sexual development.

Comparative studies indicate that, as the evolutionary scale is ascended, sexual behavior is less dependent upon hormones and more upon learning. In man, the role of hormones is limited to priming the organism for biological sexual maturation and to influencing—but not solely determining—the level of libido; the direction, nature, and adequacy of sexual performance are controlled by psychosocial factors. Thus, the many investigations of the biology of sex deviants have failed to identify chromosomal, hormonal, or gonadal aberrations; and conversely, individuals with such biological incon-

gruencies usually exhibit a sex-role identity conforming to sex-role assignment.

The remarkable variation in sexual behavior between societies as well as between social classes within a single society emphasizes the cultural determination of sexual behavior, given adequate biological maturation.

The ambivalence of Western society toward sexuality—manifested by the conflicts between official attitudes and private behavior, and the pervasive emphasis on sex side by side with sanctions against its expression—accounts for the difficulty, so common in adolescence, of attaining the basis for a sense of competence, freedom, and pleasure as a sexually functioning adult. Persons concerned with the development of adolescents have an important obligation to give them a clear and full explanation of biological function with emphasis on its *ethical significance* based upon a mutually meaningful relationship between human beings. Adolescents need a comprehensive knowledge of the physical and physiological differences between the sexes, of the development of sexuality, and of the appropriate stages of sexual experience en route to full maturity.

Commonly expressed fears that giving adolescents such information will lead to premature experimentation run contrary to clinical experience which indicates that ignorance and impoverishment of human relationships account for most sexual misadventures. A sense of inadequacy in sexuality not only impairs sexual function but also leads to disabilities in other adult roles and is an important source of psychological malfunction.

Origins of Delinquency

The search for identity is markedly influenced by peer groups. If these are constructive social groups which provide creative outlets for adolescent energy, the result is a sense of meaningful membership in the community and identification with its larger goals. If the peer group is a delinquent gang, with values antagonistic to those of the larger society, the result is likely to be antisocial personality organization—especially if the adolescent is a victim of discrimination for religious, ethnic, political, or economic reasons.

The experience of growing up as a member of a disadvantaged minority group, with attendant humiliation and denial of opportunity, makes it difficult for the adolescent to identify with the values of the society at large and favors, instead, hostility toward its norms and a disposition to anarchistic individualism. However, even under these circumstances, leadership and social forms which permit the disadvantaged adolescent to employ his energy in efforts to change unjust social patterns can foster his emergence into creative adulthood. If such opportunities for constructive social action are denied, the distortion of development leads to a frustrating and progressively more embittering "individual war against society" characterized by criminal activities.

Some theorists focus upon family pathology in explaining the evolution of delinquent behavior. Their thesis is based upon the finding that family psychopathology is frequent in the history of delinquents. The family is indeed an important agent in transmitting the behavior pattern and values expected of the adolescent by society. Consequently, distortions in family structure, whether idiosyncratic or socially induced, will inevitably have profound effects upon individual development. However, the family-centered viewpoint fails to recognize that family psychopathology is closely related to social structure and that the adolescent is also molded by social experiences outside the family.

The social consequences of economic disadvantage—poor health and reduced longevity, poor education, extralegal marital arrangements, inability to plan for future contingencies, necessity for exploiting children economically—themselves erode family structure and are likely to cause the victims of these social circumstances, the genesis of which they do not understand, to turn on each other in destructive ways. The unemployed, drifting father and the unmarried, deserted mother not only fail to provide their children with adequate nurture but also serve as poor identification models.

However, even though family structure be distorted, the adolescent may attain a degree of normal development *if* provided adequate education and constructive peer group experience. Unfortunately, the aggregation of disadvantaged families in decaying neighborhoods is all too likely to reinforce family psychopathology and, by exposing the adolescent to delinquent gangs and ineffective schooling, heighten his growing sense of bitterness.

Hazards and Symptoms

The sensitivity of the adolescent to the good opinion of his peers and the dependence of his sense of identity upon the attainment of competence in an adult role render him psychologically vulnerable to variation in physiological development, such as precocious or delayed growth, facial acne, obesity, en-

larged mammary glands in the male, or inadequate or overabundant breast development in the female. These deviations from the expected pattern of maturation, though of no great medical significance, may, nonetheless, lead to major psychological trauma if not offset by sensitive guidance.

The adolescent with limited intellectual or physical capacity can develop a persisting and even irremedial feeling of inferiority if he is forced to compete in situations in which he experiences continual failure. The individualization of educational and vocational training for adolescents is essential, both to permit the talented individual to exploit his abilities, as well as to direct the youngster with specific limitations to activities which will develop what abilities he has.

Characteristic of adolescence is fluidity of psychological structure in the struggle to attain a new and more meaningful sense of identity. In consequence, the formation of transient symptoms, resembling many of the psychopathological syndromes of adulthood, is not uncommon during this period. The clinician must exercise great caution lest he attribute too great a significance to the turbulent but temporary maladaptive patterns manifested by the adolescent. Incorrect diagnostic formulations may lead to social consequences—for example, withdrawal from school or institutionalization—that will freeze into permanence an otherwise readily correctable deviation in the growth pattern.

It is, of course, important to recognize that schizophrenia often first appears in adolescence, as does manic-depressive psychosis. However, these are uncommon disorders and may be simulated by panic reactions in the youngster who is confronted by overwhelming internal and external stimulation. If the recent trend toward a specialty of adolescent psychiatry has any justification, it lies in the opportunity for psychiatrists to acquire particular competence in the differential diagnosis and special management of adolescents' adjustment reactions. Experience with the psychiatric problems of adolescents leads to respect for their extraordinary range of individual variability and their remarkable restorative capacity under corrective and supportive experience.

The psychological basis for a sense of individual worth as an adult rests upon the acquisition of competence in a work role during adolescence. A sense of competence is not acquired on the basis of "reassurance," but rather upon the actual experience of succeeding in a socially important task. The challenge to the educator, therefore, is to stimulate abilities to the utmost without setting standards so high that they lead to an enduring sense of defeat.

The educational accomplishment must be matched by an opportunity for the individual to exercise his competence as a worker in the economic world. The sustained motivation necessary for mastering a difficult work role is only possible when there is a real likelihood of fulfilling that role in adult life and having it respected by others. The task of providing full employment in a world in which automation is revolutionizing traditional work roles provides a challenge to the abilities of leading thinkers in all societies.

The World's Hope

No society can hope to survive that does not succeed in harnessing the constructive, searching suprapersonal and supranational drives of the adolescent. In recent world history, adolescents in underdeveloped countries have participated heroically in overthrowing the dead hand of the past and attaining the beginnings of a meaningful nationhood. The picture in the relatively developed countries is less clear and less heartening. As affluence is attained, societies tend to become frozen into traditional molds, with resultant trends toward self-preoccupation and egocentric goals that afford less challenge to adolescents. There are, fortunately, notable and inspiring exceptions to this self-preoccupation, as youngsters dedicate their energies to improving the lot of disadvantaged fellow citizens and to social betterment in underdeveloped countries far from their shores.

The capacity for engagement in meaningful social activity is clearly present in young people in every country of the world. The challenge to the behavioral scientist is to help his own country develop the forms and means to enable the adolescent to take a leading role in the struggle for the attainment of a world in which peace, freedom, and economic opportunity are omnipresent. No task is more suited to the adolescent. No task has greater potentiality for permitting the full flowering of his capacities.

Thus, the provision of an optimal framework for adolescent development is inseparable from the struggle to create a better world by helping to mold the citizens who will build it.

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[1] Flavell, J. H.: The developmental psychology of Jean Piaget. Van Nostrand, New York. 1963.

[2] Erikson, E. H.: Identity and the life cycle. *In* Psychological issues, monograph 1. International Universities Press, New York. 1959.

A PSYCHIATRIST'S TECHNIQUES IN TREATING ADOLESCENTS

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ADOLESCENTS in increasing number are being referred to psychiatrists for evaluation or treatment. Because they are notably difficult to reach and to keep in treatment, working with them requires techniques in many ways different from the techniques used with adults or children. The following observations are based on my experience with about 350 adolescents, between the ages of 13 and 21. They are not presented as the only way to work with teenagers, but as measures which, in my experience, have generally proved successful and which therefore might be found useful by others.

The Initial Interview

One of the first difficulties encountered in psychiatric work with adolescents is that most of those referred for evaluation or treatment do not want to see a psychiatrist. Generally, the young person has heard that psychiatrists are for "crazy" people, and he resists being classified as such. Usually, the psychiatrist has been chosen by his parents through consultation with the family doctor, teachers, or friends, and the adolescent resents having to confide in someone who must be a parent ally.

All this makes the adolescent's first visit crucial to the success of the therapy. The therapist has to convey to him that *he* is the one the therapist is directly interested in helping, not his parents; that he is not crazy but has difficulties that can be helped if he will talk about them; and that what he says will remain confidential.

I have found that if I first see the adolescent before I have gathered any information about him, my initial contact with him is so spontaneous that he rarely resists confiding in me. I inform him that I know nothing or very little about his difficulties and I would like to hear from him what they are. If I still don't get much information, I ask him about the composition of his family, his friends, his hobbies, his school (all fairly neutral subjects), and then I return to the question of why he has come to me.

Only toward the end of my first appointment with the adolescent do I ask him if I can see his parents to hear about their view of his difficulties. By this time, the adolescent's confidence has almost always been gained, and he offers little resistance to bringing his parents to my office. Asking him to bring them in himself gives him the satisfaction of "inviting" his parents to talk with me.

Occasionally, when the adolescent brings his parents to my office, he comes into the room with them. I make no comment about this and allow him to remain. For example, a 17-year-old girl had been very suspicious of me throughout my first interview with her. She did not believe that I had not been in touch with her parents and angrily refused to tell me the reason for her referral, saying that I knew it already, and asking why she should bother to repeat it. When she brought her parents to my office, she came in with them. I asked the parents what difficulties they were having with their daughter and then asked the patient how she felt about her par-

ents' complaints. She slowly came to realize that I had been truthful and had not previously been informed of her troubles. Before the end of my interview with her parents, she asked to see me again, but alone.

The Relationship

Once the first contact has been made with the teenager, how does the therapist involve him in treatment? Adults, if they want help, are ready to work in psychotherapy; children see the therapist as a playmate and enjoy the attention that the therapist gives them. But teenagers often do not see why they need a therapist and their motivation to work with one is often very weak.

For this reason, the therapist has to get the adolescent involved in treatment very quickly in order to keep him in treatment. The therapist has to work to create a positive relationship, and once this is established has to work at maintaining it. He has to avoid comments in the early sessions that sound like remarks the patient has heard from parents or from other adults with whom he is having difficulties.

I lost a patient a few years back because I told her in my second interview with her that she struck me as wanting to rule other people's lives. This was after she had asked me to sit in a different chair, to talk only when she asked me to, to look in one direction, to use a different lighting in the office. My remark was poorly timed. A positive relationship had not yet been established, and I created in her a strong negative reaction to me which I could not work with efficiently, not knowing enough of her history. She left me after three or four more interviews because she "hated my guts"—I was "just like her father."

It is important, however, not to be "too nice" in order to win the patient over. Adults rarely insult the psychiatrist when they start treatment—they come because they want to come. On the other hand, adolescents are often verbally assaultive when they first start working in psychotherapy, especially if they have been forced to come in some way. Although it is important to adopt a patient attitude toward their vindictiveness, the therapist should not respond with too much kindness. If he does, and if the patient is suspicious, the suspicions may be increased—"Why are you so kind to me when I am so nasty? You can't like me the way I act; you must want something from me" is a typical response.

I have worked, and still do, with a 13-year-old boy who in the early interviews called me "woman" or "spy," and became more and more paranoid as the weeks went by. One day, wondering if my tolerant and warm attitude toward him might be making him suspicious of my intent, I decided to react more naturally to his nastiness and told him that I was fed up with being treated the way he treated me, that I did not especially enjoy working with him, but that this is what had to be, and so was. From this time on, the patient became less paranoid and slowly started relating to me. Later, he told me he had questioned my motives when I first saw him because my behavior was so unnatural that he felt he could not trust me.

In addition to building a positive relationship with the teenager—or in order to build it—the therapist has to come out of his own shell a little. The teenager is still in search of adults with whom he can identify and one has to allow him to know something about oneself in order to facilitate the identification.

Free Association

How does the adolescent work in therapy? Can he talk freely about whatever comes to mind, or, in psychiatric terms, "associate freely"? He can, but he will not go about it the same way as an adult. When he is overly anxious, he is most apt to be quiet. Rather than motivating him to confide, too much anxiety is apt to block his ability to communicate. He may feel engaged in a battle of wills with the therapist over who will give in and talk first—a struggle which the therapist would do well to avoid. I often tell the patient that I feel this struggle is going on, that I am not interested in winning a game with him, that I *am* interested in helping him and am ready to talk first if this will help him to talk.

Sometimes I ask the adolescent, "What's on your mind?" although adolescents' usual response to this question is: "Nothing." When this happens, I may point out that I realize that this question must be annoying, that I would like to find other ways to formulate it but cannot, and then I suggest that perhaps he, the patient, could tell me the kind of question it would be easier for him to answer. If said with sincerity, this has a magic effect. Not only does the patient communicate his thoughts, but the next time I ask him what is on his mind I have a feeling that he smiles forgivingly as he goes ahead with his answer.

In a few instances, in which a very angry patient has remained silent for a long period of time, I have allowed him to remain in my office but have glanced through a magazine as he sat there. After a while, I have made some comment about what I was seeing

or reading and soon the patient has joined me in talking about it. Thus the ice has been broken.

Sometimes I "free associate" with a nontalking patient. I tell him what I think might be going through his mind. Often, in such instances, the patient has interrupted my talking either because he has been surprised that I have read him well or because he has become angry at my projecting my thoughts on him.

When a patient is silent in an evaluation interview, I may ask him to draw a picture. I do this not only because I am interested in what he produces—which I am—but also because, as he concentrates on his drawing, he relaxes his efforts to ward me off and begins to talk more spontaneously.

Phrasing Questions

Adolescents are much more defensive than adults, and direct questions often reinforce their defenses. However, the therapist can get the information he wants by asking a question indirectly or even giving some suggestion of an answer in phrasing it. The question "How do you feel about not having any friends?" is rarely answered by "lonely." However, the response is usually frank if the question is phrased, "I wonder if at times you don't feel lonely, not having any friends?" If this suggestion reflects his feeling, the adolescent nearly always admits his loneliness and begins to talk about it; if he does not feel lonely, he does not hesitate to say so and will often voluntarily begin to talk about the way he does feel. I like to compare this technique with pump priming, a small but essential task in getting water to flow.

Teenagers are especially guarded about their sexual fantasies, feelings, and actions. Because this area is an important source of disturbance, it cannot be overlooked in therapy. However, the subject has to be approached gradually, by reminding the patient occasionally that this is an area that will have to be discussed sometime before the treatment is over, although there is no immediate necessity to talk about it now.

A teenage boy who was in treatment with me for a period of 2 years used to cancel his next appointment every time I broached the subject of his feelings about sex. After doing this three or four times, he came to realize that these cancellations were directly related to my attempt to broach the subject. Therefore, after my fourth attempt, he kept his next appointment, but came in announcing that he was going to stop treatment. I told him then that I felt he wanted to avoid this important subject; that obviously he had problems in this area since he could not talk about it; but that if he wanted to stop coming for treatment, I could not keep him coming. At the same time, I told him that if he did remain in treatment I was going to increase my fee, since he was working now and could afford to pay more. To my great surprise, after a fairly long silence, he said that he had changed his mind and that he would remain in treatment. And he asked: "Can I start now to talk about sex?" He began then—and continued in several subsequent interviews—telling me about his sexual fantasies and experiences, which had deeply frightened him.

Independence

How does a therapist deal with the adolescent's need for independence? I do my best to enhance it in a practical way. If the adolescent is working, I often reduce my fee so that he himself can pay for treatment instead of relying on his parents. If he is not too disturbed, I encourage him to come to my office alone. I also do my best to schedule the appointment at a time which is mutually convenient for him and for me. I treat him as an adult who has his own rights and often call him Mr. ——— (or Miss), rather than by his first name.

The teenager must realize that although the therapist believes that he needs treatment and should, for his own sake, keep his appointments, the therapist does not need him in any emotional way, as too often his parents do. Moreover, the therapist must be careful not to act like a parent by doing things *for* him. If the therapist is tacitly or overtly encouraging the adolescent to work, or go to school, or to live away from home, he should beware of getting involved in the realization of the project. This must come from the adolescent himself. Too much zeal on the therapist's part may often end in a painful failure, since any resentment or hostility the teenager has against the therapist may be expressed in an action to defeat his efforts. For example, job and therapist get linked instead of job and patient. How can a young patient more easily get even with his therapist than by leaving a job the therapist has taken pains to secure for him?

Acting Out

Adolescents in treatment are prone to act out their anxieties, sometimes with bizarre or threatening behavior. Parents often react to such acting out in kind; a therapist should not follow the same pattern.

Teenagers often feel that the more they act out, the more attention they will get. This, unfortunately, is frequently the case, but the therapist should not encourage it. I am willing to see a teenager outside his regular appointment hours if he is genuinely upset, but I do not panic when a teenager phones me saying he has taken pills and is going to die. On such occasions, I have informed the patient that I would call his parents or the police and tell them to take him to the hospital's accident room and that I would see him at the time of his regular appointment with me.

Acting out is sometimes part of the adolescent's scheme to be regarded as a "special patient"—a "very sick patient."

For example, one day a teenage girl asked me what her diagnosis was and I replied, "adolescent situational reaction." She waited a while, then, to my surprise, pensively said, "I am sorry I am only that—even after the crazy things I have done." Her behavior changed drastically from then on.

If the adolescent develops a strong positive relationship to his therapist, this may limit his acting out. For instance, a girl who was in treatment with me for 2 years refused to finish high school after her discharge from a mental hospital. I told her that going on to graduate was a condition of my working with her and that, while I could not force her to do so, if she chose to continue in treatment with me she would have to go back to school. She did go back, graduated, and was accepted for admission to college. On the day she received the college acceptance, she telegraphed me: "Thank you for having insisted that I complete high school—I made it to college."

However, a therapist should not take a position if he is not prepared to see it through. Consistency is one of the great virtues of a good therapist. The patient has to know that the therapist means what he says.

The Patient's Parents

Honesty is an essential virtue in the therapist. I tell all my patients about any call I receive about them. I let them know at the beginning of my work with them that I will do this, and I carry it through consistently. I also tell them that I will not see their parents without their permission. This has worked out very well. When crises have arisen, making it necessary for me to see the parents, I have always been able to get the patient's permission to do so.

Allowing the patient to express his anger toward his parents is part of any therapy. However, the therapist has to be careful not to side with the patient against his parents. I once almost lost a patient in treatment when I repeated what he had said to me—that his mother did not seem to care for him since she had turned him over to the department of public welfare. For at least 6 months afterward, the boy refused to enter into a therapeutic relationship. He told me he hated me, that I was no good, that I wanted to hurt him, and, eventually, but much later, that I had insulted his mother. It took 6 months for him to tell me what I had said that had made him so angry. It is all right for the patient to denounce his parents, but it is a serious offense for the therapist to do so.

The advisability of seeing the parents of a teenager while he is in treatment has to be considered individually in each case. I do not make a habit of regularly seeing the parents. If the parents need support during their child's psychotherapy, I refer them to a colleague or a social worker. I do not want to become, in the adolescent's mind, a friend of his parents; I want to remain his own doctor.

Termination

The question of when to terminate an adolescent's treatment presents considerations different from those which are present in working with adults. In treating a teenager, it is not usually advisable to allow him to regress. The emphasis is on allowing him to grow up. Treatment should stop when the main issues involved have been worked through.

The teenager has to try his own wings. To keep him in the frame of psychotherapy for too long a period of time would impede his growing up. Therefore, as soon as I believe that a patient has reached a point at which he can handle his presenting problems without any help, I end the therapy, pointing out that if in the future he would like more assistance he may be able to get it then. I make it clear that I am now confident he can do well without me.

Evidence that children needing the most help are the least served leads to . . .

SUGGESTIONS FOR REFOCUSING CHILD GUIDANCE CLINICS

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A COMMENTATOR on metropolitan trends once wrote that the core cities of our Nation have come to be "the abode of the rich, the poor, and the slightly odd."[1] The rich can purchase relief from the stresses of living in the core city, and at the same time profit from its many advantages. The "slightly odd" are mainly those who do not have 2.2 children, or who dislike the conformity of the suburbs, or whose work demands that they live in town. The poor are mostly members of the unskilled working class, a large proportion belonging to ethnic minorities. Many of the poor are new arrivals to the city, such as the economic refugees from Puerto Rico, the social and economic refugees from the Deep South, and the "poor whites" from Appalachia. While all these new arrivals in the cities have adjustment problems, most of them need relatively little professional help. Opportunity is what they require, and many are making splendid progress, as did their predecessors—the great waves of immigrants of the past.

However, any large mass of people under stress is bound to contain many families and children who need specialized help. Their problems are aggravated when they are locked into the city's crowded core, as are large populations of the poor today, who are experiencing environmental pressures somewhat different from those experienced by the immigrants of the past. They cannot move onward, or upward, because of reduced open spaces, high costs of living, dwindling demands for unskilled labor, and racial discrimination in employment and housing. The resulting frustration is reflected in today's rising crime and delinquency rates. It is compounded by the inadequacies in the organization and administration of children's services.

Working in New York City's central borough of Manhattan, a prime example of a city's core, the Manhattan Society for Mental Health has a particular concern about the availability of outpatient psychiatric services to children of the lowest socioeconomic groups.

On the basis of Hollingshead's socioeconomic classification, as applied in New Haven, Conn.,[2] about two-thirds of the core-city population (unquestionably more in Manhattan) are in Classes IV and V, the semiskilled and unskilled, marginal, and dependent groups. This population contributes much more than a proportionate share to the caseloads of the courts, juvenile institutions, jails, mental hospitals, child-caring agencies, and the rest of our social and public health services.

In 1963, the Manhattan Society for Mental Health (with support from the Field Foundation) undertook a year-long study to learn whether children of Classes IV and V in Manhattan were getting

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Based on a presentation to the general staff meeting of the Catholic Charities Guidance Institute, Archdiocese of New York, September 1964.

their share of psychiatric clinic services.[3] The society sought answers to the following questions:

- *Recognizing that there is a scarcity to begin with, which children are getting whatever service is available?*
- *How does this relate to their socioeconomic status?*
- *Are children of low socioeconomic status getting a reasonable share of the service?*

In the course of the study, data emerged on the question of *who tends to serve which socioeconomic classes.*

The study consisted of three parts: (1) analysis of a year's statistical reports of all the outpatient child guidance clinics in Manhattan; (2) detailed study of the waiting list of one voluntary clinic which has a stated policy of serving children of low socioeconomic status; and (3) a series of 40 field interviews with persons in the community who are most likely to be seeking psychiatric help for children, such as teachers, school guidance personnel, clergymen, court workers, and the like.

Cases Treated

We found that during the year 1962, a total of 5,851 children under 18 living in Manhattan were served in some direct way by the outpatient clinics in the borough. Of these, only 828, or 14 percent, actually received treatment, as defined by the clinics themselves. The others received diagnostic services chiefly and such other kinds of attention as psychological testing for administrative or educational purposes.

Looking for reasons why only 14 percent of the children seen received treatment, we tested the assumption that the rest of the clinics' time went into consultative work with schools, courts, and other agencies in order to help them do their jobs better.

However, our interviews with the people in the community who seek clinic care for children indicated otherwise. Interviews with referring sources revealed a strong and consistent sense of frustration in regard to the mental hygiene clinics—their intake practices, policies, and services. If the clinics had been doing useful diagnostic and consultative work in relation to the 86 percent of the children who were not treated, either the referring sources did not appreciate it or did not know they were receiving it.

Among the clinics that provided the most intensive treatment to children (as measured by average number of interviews per case), the average number of interviews per case was six, thus raising the question of whether the clinics handled a large number of cases with brief, nonproductive contacts. The data showed that the majority of cases that received six or more treatment interviews involved children living in the better off neighborhoods.

This led to the question of who was actually served. In relation to the total population, we found that the children of the poor, especially the "poorest poor," received proportionately less service than children of higher status families.

Who Serves Which Children?

On the question of which types of clinics served which kinds of children, we found that, by and large, the clinics under voluntary auspices (even those supported in large part by public funds) tended to serve the economically better off children, while the poorest children were served mainly by public agencies such as city hospitals, the school system's own child guidance clinics, and juvenile court clinics. Agency auspices are not supposed to make any difference in quality of service or population served. Nevertheless, they clearly do. The voluntary clinics served about one-quarter of all the children seen in the clinics, but treated three-quarters of all children who received treatment—again the economically better off from the better neighborhoods, those most likely to be what Caplan [4] has characterized as the "good" cases.

Corroborating this, the study of a waiting list—a source of great irritation and frustration to those who make referrals—indicated that the self- and family-referred cases on the list were most quickly accepted for treatment, while the court- and police-referred cases had to spend the longest time waiting and often, because of changed circumstances during the waiting period, were never reached. Thus, the waiting list itself was revealed as only a pool from which cases are selected for treatment, with the most troublesome and potentially harmful cases to the community tending to remain on the bottom.

The existence of two systems of clinic care was thus demonstrated, one under public and the other under voluntary auspices. The system under public auspices is relatively nonselective, more overloaded, and gives a somewhat curtailed service. Its clients are almost exclusively children of lower socioeconomic status. Most of them are referred by public schools and the courts. The system under voluntary auspices, but supported by a good deal of public

money, serves patients of higher socioeconomic status, mainly self-referred or from medical sources, and is much more selective about the children it accepts for treatment.

There may be good reasons for having more than one system of care. Even so, the two systems, taken together, should constitute a pattern that covers community need. The present picture indicates seriously inadequate planning, inappropriate or narrowly focused services, and, in some cases, self-delusion on the part of the community and the mental health professions themselves. Furthermore, the same inadequacies are surely demonstrable in almost every other American city.

Neglect of Urgent Needs

There has been an alarming increase of children entering State mental hospitals over the past few decades, but little organized effort to do much about it. Between 1888 and 1910, there was only one admission of a child under 15 to New York State mental hospitals. Ten years later, there were 21 in one year. In 1950, there were over 250. And in 1963, there were almost 1,600 child admissions. Estimates based on present trends in New York State are that the 1963 figure will be increased by over 100 percent by 1970.[5]

The outpatient clinics do not seem to try to cope with the problem of seriously disturbed children, but concentrate their attention on children with milder disorders. Yet the future problems engendered by placing children in large mental hospitals are apt to be complex and intractable. Once a child enters a State hospital, he is likely to remain there much longer than an adult and to present much more difficult aftercare problems.

When the increase in child admissions to mental hospitals is considered, along with parallel trends in juvenile delinquency statistics and other indices of emotional disturbance, the impression is strong that most of our psychiatric services for children are being aimed at the fringe of the target, not at the center. If this is so, merely to expand services as they exist will not solve the problem. Practical, meaningful help must be directed to the "bad" cases; in addition, help must be given to all the other health, welfare, and correctional agencies of the community that try to cope with such cases. Of course, the clinics alone cannot be expected to do the job of preventing serious emotional or social breakdown; a broad range of health and welfare services for children is needed. Nevertheless, the first obstacle to effective participation by children's psychiatric clinics is that many of their approaches are simply inappropriate to the needs of the children of poverty-stricken families.

What is needed is a far higher priority of concern about the poorest children on the part of the mental health professions. If these professions are to be socially effective, they must adapt their clinical methods to the needs of these children. They must also make greater efforts to bring their mental health concepts to the aid of the basic community health and welfare services, and thereby spread the effects of their knowledge to the agencies which bear the brunt of people's problems. They must participate in forming the kind of interagency network that will not have holes in it large enough to screen out children needing service.

Applying Concepts

Mental health services are not a panacea for all the ills that befall children. Nevertheless, they can have broad impact on children's health and welfare if used more creatively and more economically.

Our institutions for neglected children contain many damaged children, but they do not all need to be turned into little psychiatric hospitals. They need, basically, to be better child welfare institutions, with consultative help from the mental health professions.

By the same token, it is neither necessary nor appropriate to convert juvenile probation departments into psychiatric clinics. Admittedly, most such departments do need additional clinical services, but primarily they need more good probation officers, better trained (with the aid of the mental health professions), and better paid. The courts also need more help to enable the judges to do their own work more effectively. With this, the judges and probation officers would be able to make better use of clinical services.

But to accomplish this, the clinics, in the first instance, need to be more interested in the problems of the most beleaguered portions of our population and more active in giving help *with particular understanding of the social class factors involved.*

In addition, since no agency ever has enough funds or personnel to serve all comers, it is imperative to establish a *system of care* in each community or defined service area, so that available, appropriate help is directed to deviant children soon enough to be of help.

Such a system would provide a wide variety of

easily accessible services, in accordance with the needs of the child—and of his family, for the two are inseparable—with the rapid assumption of responsibility for the case by the system of care, *no matter what the presenting problem.*

At the present time, procedures in seeking help for disturbed children place an unwarranted and unreasonable burden of responsibility on the applicant or on the referring source. In effect, the referring source—whether teacher, a clergyman, or a parent—is expected to be sophisticated enough to refer the child to the service especially suited to his problem; he is expected to be able to decide whether the situation requires child welfare, psychiatric, or family services. In a large city, with numerous independently operating agencies, this is a high expectation. If the referring source applies to the wrong type of agency, he is given the unfair burden of shopping around for the right kind. Sometimes he is given advice, but the problem is left with him, so that he becomes frustrated or hostile and rejecting of professional services, or else makes an inappropriate approach to the next agency, thereby compounding the problem—all at the expense of the child who needs help. Too often, he just gives up.

Waiting List or Defense?

The matter of the eternal waiting list needs immediate attention. If mental health agencies consider their services to be preventive of mental illness or deep emotional disturbance, it is paradoxical for them to ask the client to make himself available at the point of the agency's readiness, rather than his own. At the time he applies, the applicant is likely to be at a relatively high point of readiness to work toward solving his problems. His application represents some kind of awareness of crisis—actual or pending. He may then be as ready to participate in attempts to change the situation as he ever will be. Yet he is asked to wait for periods that are sometimes ridiculously long, and this is rationalized on the basis that if he is "really motivated," he can withstand the stress.

Intervention at time of crisis is said to be most effective. Does not this imply that speedy contact with the client is likely to result in more productive, even briefer service? Would not the agency thus be able to serve more clients per year?

Clinics should ask themselves a number of questions in connection with the waiting list problem. Why should the standard time for an interview be an hour, or even 45 minutes, as in psychoanalysis? Is psychoanalysis an appropriate operational model? Is it necessary or even desirable in every case? If many clients have a low tolerance for waiting lists, perhaps there are many with low tolerance for long interviews as well. Would it be possible to determine which clients could benefit from briefer interviews? Or, to put it another way, is it a fact or just an assumption that shorter interviews will be of less benefit to the client?

Then there is the question of when to terminate the case. The average duration of a case in psychiatric clinics in New York City is between four and five interviews.[6] A great many cases are terminated by the client rather than the therapist. This fact should be faced. It might be productive, for example, to experiment at the outset with client-therapist planning in regard to how many interviews shall be offered.

Cooperation for Efficiency

Interagency relationships require some scrutiny. At present, referring sources often terminate their own service to a child or his family on the basis of "giving the clinic a free hand." Or the clinic may not wish the referring agency to continue its contact because this might "interfere with psychotherapy." Meanwhile, the patient may fail to benefit from psychotherapy because he also needs some kind of supportive, stress-relieving service that the referring agency can give as a supplement to psychiatric treatment. There seems to be a good deal of room for exploration of the possibilities of cooperative work without anyone having to surrender jurisdiction, prerogatives, or standards.

Another potential for expanding actual service might be realized by taking a hard look at the concept of the clinic team. Are so many interdisciplinary conferences needed? Is the intake worker given enough authority to make commitments for the agency? Is the patient put through a series of interviews and tests when the kind of treatment needed is fairly apparent from the outset? How much would actually be lost through rapid decision-making and case assignment?

Many of these questions could be resolved by planning in relation to a *system of care*, as opposed to an individualistic, agency-focused policy. This would change the tendency to evaluate the applicant in terms of whether he fits the agency, to evaluation of what he needs, how it should be supplied, and where the services can be found. This kind of perspective calls for consideration of such mechanisms as joint

interagency intake or evaluation services, through which a variety of children's services can be supplied as needed without the delays and frustrations caused by interagency referral for more intake interviews and independent evaluations.

Rationalizing Services

A positive approach to the many problems children present today would accordingly embrace these principles:

1. The need for increased efficiency in psychiatric services to children in a given community requires thinking in terms of a comprehensive system of care which offers a wide range of social, psychiatric, and health services that flow into each other and makes it possible for the ***community's system to assume continuing responsibility for service,*** no matter at what point the client makes his first contact. Thus, a child guidance clinic should be concerned not only about psychopathology and psychotherapy, but also about whatever service is needed to restore equilibrium to the disordered child or family.

2. In planning therapeutic approaches, both community and child can benefit from ***speedy intervention in time of crisis and for relatively brief periods,*** sometimes limited to supportive help, the duration of which may be determined in advance.

3. When the clinic cannot accept primary responsibility for a case referred, it should provide ***case consultation and guidance to the referring source*** or to the agency carrying the primary responsibility for the case.

4. From the standpoint of internal administration, ***the concept of the "team approach" should be re-examined,*** in order to learn whether cases may be taken on more speedily by giving more responsibility to individual workers. This implies experimentation in classifying forms of intervention that can be offered by the clinic or other agency and in the immediate assigning of cases for appropriate help.

5. ***Clinics should be easily accessible to all agencies*** in the community having concern about children and families, ***and should provide them with practical, program consultation.*** Thus, the clinic would seek not only to supply intensive, continuing therapeutic effort to a selected group of cases for well-defined reasons but would also help generally to improve service for children who need and can benefit from other types of help.

6. ***Decisions of clinics or other agencies about helping in a given situation should not be based on "either-or" thinking,*** but rather on answers to the questions: "What kind of help can we give? What order of responsibility shall we accept in this case? What kind of help can we *find?*"

The Will To Help

In addition to a good deal of soul searching and willingness to adapt to new circumstances, these principles may call for the surrender of some time-honored customs and jealously guarded prerogatives. They call for skilled, rapid decision-making at intake. They may call for joint intake services, or at least joint evaluation, by clinics and family and children's services, and certainly for closer operational ties among all child welfare and family services. They may well call for some kind of central record keeping system. They call for continued interest in cases not accepted for treatment and willingness to supply more consultation services to other agencies, so that referral of an applicant elsewhere is truly referral and not simply disposal. They call for constant self-evaluation and self-criticism, as new devices are created and tested.

These are not easy means to adopt, but the results would be worth the effort. They would make mental health services a much more vital and broadly useful force in the community's total effort to serve the needs of children.

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A one-county pilot project provides lessons for . . .

EXTENDING THE RANGE OF CHILD WELFARE SERVICES

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FOR THE PAST 2 YEARS, public welfare departments, stimulated by the 1962 Public Welfare Amendments to the Social Security Act, have been making important moves to extend the scope and range of services available to families and children. In New York State, where foster care and adoption services under public auspices were already available throughout the State when the amendments passed, the goal has been to make four other types of services similarly available on a statewide basis: family counseling; protective services; homemaker services; and family day care. These have been selected as the services most needed and most appropriate for adding to the programs of local welfare departments.

When such a significant extension in program is proposed on a statewide basis, it is necessary to begin slowly and to test theories about how the new services might be integrated with those already operating. The device the State welfare department selected to accomplish this testing was a pilot project through which the four services would be added over a period of several months to the program of a local public child welfare agency—specifically the Children's Division of the Rensselaer County Department of Public Welfare. Introduced gradually by the agency, the four new services were eventually combined in a newly organized unit, known as the Home Services Unit, which has now been in operation for 2 years. The experience in developing these services and the problems encountered in the process have brought up some questions for consideration as the broadened program is introduced throughout the State.

The Rensselaer County Department of Public Welfare serves a half-rural, half-urban county of approximately 140,000 population, which covers an area 35 miles long and 25 miles wide. At the time the project was initiated, the Children's Division, under the general supervision of a division supervisor, was divided into three units designated as Intake, Under Care, and Homefinding and Adoption. The division was caring for 836 children, of whom 310 were in foster care, 496 in their own homes, 10 in adoptive homes, and 20 in a variety of other types of care. The Under Care Unit was responsible for services to children in their own homes as well as to children in foster care.

Homemaker Service

The first of the new services to be initiated through the project was homemaker service. The initiating stages took approximately 2 months. On request of the commissioner of the local welfare department, the county board of supervisors created three homemaker positions in the noncompetitive civil service classification, establishing a salary rate which ranged between the rates for clerical and casework staff, and, in conjunction with the Rensselaer County Civil Service Commission, prepared a duty statement for the future incumbents. A plan for the operation of the homemaker service was then devised and submitted to the New York State Department of

Social Welfare for approval, since the project was to be supported largely by State and Federal child welfare services funds.

A supervisor from within the agency was assigned to the newly created homemaker service on a half-time basis, her duties to include recruitment and training as well as supervision. The request to the New York State Department of Social Welfare for financial support included reimbursement on salaries only. No request for transportation funds was made.

After approval of the plan by the board of supervisors, the county civil service commission, and the New York State Department of Social Welfare, a recruitment ad was run in the local newspaper. Enough women responded to allow for choice, and three were selected as the first homemakers. They were placed on staff in late April of 1963. Except for one replacement, the homemaker staff has since remained the same.

Training. The newly recruited homemakers were given a 1-week course of group training by their supervisor. This included orientation to the agency with interviews with agency personnel; a field trip to a child-caring institution within the area; introductions to visiting nurses from the local public health department; a meeting with a home economist, who discussed meal planning and the use of surplus foods; and orientation to the job of homemaker through the use of material prepared by Rutgers University.[1] At the end of the week the homemakers were told about the situations in the families they were to serve, introduced to the caseworkers assigned to these families, and introduced to the families themselves through home visits.

Supervision. Since the beginning, the homemakers have met with their supervisor individually every week, and as a group once a month. In the individual conferences, the caseworkers assigned to the same case as the homemaker have been brought into the conference when appropriate.

The group meetings have been used to convey information of an administrative nature and for continued training. Pertinent literature has been read and discussed. The homemakers themselves have in many instances suggested subjects which they would like to be the focus of future conferences. These meetings have not been used to discuss individual situations in which the homemakers have been involved.

Some Figures. In the 2 years since the service began, 34 families with 176 children have been served by the homemakers. Analysis of these 34 families shows that 25 were referred from within the welfare department—18 from the Public Assistance Division, and 7 from the Under Care Unit of the Children's Division—and 9 were referred from outside the agency. Two of the out-of-agency referrals came from hospitals and one from a mental health clinic; the other six were self-referrals.

Of these 34 families, 19 were 2-parent families, though in 7 the mother was temporarily away because of illness; in 8, the mother was pregnant; in one, the children were being neglected; and in 3, the parents had inadequate child-care standards. In the 15 1-parent families, the parents had been long separated by death, divorce, incarceration, or other circumstances. In seven of these, the father only was present; in eight, the mother only. In the latter, three of the mothers had insufficient child-care skills, and five were handicapped by pregnancy or illness.

A review of the case records reveals that the homemaker service kept 144 of the children from being placed outside their own homes. The 20 children who had to be placed in foster care in spite of having received homemaker service belonged in 4 families—in 2, the lone parent had to be placed in a mental hospital; in 1, he, a stepfather, discontinued the service; and in 1, the father's working hours made it impossible to continue homemaker service until the mother returned from a hospital. In three families in which the homemakers were sent in to teach the mothers, placement was never an issue.

The Service. The service has been used both to provide mother substitutes in emergencies and to train mothers whose child-care skills are inadequate In some cases, both types of service have been provided, in the sense that upon the mother's return from a hospital the homemaker's role has become, in part at least, a teaching role. An analysis of the hours of service given the first 21 cases shows that in spite of the fact that over four times as many cases primarily involved substitution for the mother, only 62 percent of homemaker hours were devoted to the mother-substitute cases, the remaining 38 percent being devoted to training and teaching.

The hallmark of this program has been flexibility. The ability to assign homemakers full time, part time, for irregular hours, and to a variety of situations has accounted for a large part of its success.

The agency has also found the availability and quality of supervision for the homemakers to be of utmost importance, since these women work long

hours in situations which are invariably difficult and taxing, and need a supervisor's support.

However, the undertaking of both types of homemaker service—mother substitution and training—has caused some difficulty. In some instances a homemaker has been involved in a program of training with a mother when the need for her services elsewhere as a mother substitute in an emergency has arisen. The interruption of the training program has resulted in a loss of ground in the first mother's training. A larger program with more homemaker staff would reduce, if not eliminate, this problem, making it possible for homemakers to specialize in one or the other type of service.

No records have been kept regarding the number of children and the number of referrals made for which no homemaker was available. However, it has not been necessary so far to place any children in foster care because a homemaker has not been available. In some instances, the supervisor has referred families needing home help to the agency's employment counselor, or directly to persons who have expressed interest in becoming homemakers. In these situations, the homemaker does not have agency supervision nor is casework provided to the family.

Family Counseling

In August of 1963, both family counseling and protective services were initiated and the Home Services Unit established. The supervisor of homemakers became the unit's full-time supervisor.

The family counseling service—or "preventive service," as it is known in the agency—began with one full-time caseworker, but a second was added before a year was out. This service was designed for families seen in the Intake Unit, the Under Care Unit, and the Public Assistance Division whose problems seem to have "potential for change" under intensive long-term casework treatment.

Facts and Implications. In the 21 months since the inauguration of the family counseling service, 35 families, with 147 children, have received casework service. However, because of the travel time involved and the intensive nature of the service, individual caseloads have never been more than 17 families (67 children) during any one month.

The question of placing the children in foster care has been one of the most frequent issues to bring the families into counseling or to arise during treatment. Nevertheless, only 10 children from these families have been placed in foster care, and, of these, 8 have since returned home. Most of these placements were necessitated by temporary family emergencies. In two instances, however, the child has required long-time foster care because of emotional difficulties in which unresolved interpersonal problems in the family have been intimately involved. In one situation, two children in foster care at the time the family was referred for counseling service were enabled to return home as a result of changes brought about in the family in the course of treatment and the use of homemaker service.

Some Lessons. In the first 10 months of the counseling service, one of the workers used 21 different community resources in helping the families in his caseload—a point which underscores the fact that an effective counseling service does not, indeed cannot, operate in a vacuum. Some of the resources used were available within the agency itself, such as work relief, employment counseling, and surplus foods. Others, such as legal, mental health, and medical facilities, were available in the community.

While "potential for change" has been one of the criteria for selecting cases for the counseling service, the staff has had to alter somewhat its original idea that this must involve an obvious motivation for change on the part of individuals. The families served have on the whole been of low socioeconomic status, with little education, and as a consequence have had difficulty in understanding the purpose of the service. They frequently have not been able to comprehend readily that anyone would be genuinely interested in helping them with their problems on a continuing basis. Rarely has a family requested the agency for help with a problem recognized as one it could do something about—more often the recognition has come from an agency staff member. Consequently, the process of engaging the clients in a continuing relationship has required a high degree of skill and patience on the part of the workers. Much remains to be learned about effective techniques for providing long-term casework for persons not geared by education or experience to seek and use it.

Protective Service

One worker in the Home Services Unit carries full responsibility for the protective service. This service focuses on cases of serious neglect or abuse in which immediate harm to children is threatened. The protective worker works with the family to secure improvement in the home or make other arrangements for the care of children. He is expected to

involve the authority of the court when this is necessary to secure adequate protection, care, and treatment of children whose parents are unable or unwilling to use the help offered.

Protective cases come primarily through the Intake Unit of the Children's Division, although occasionally a case being carried in the Under Care Unit, in which a critical situation has arisen, is referred for the service. In spite of a 1964 State law requiring doctors and hospitals to report cases of suspected child abuse to the public welfare department, only two referrals for protective service have been received from this source.

Protective Caseload. During the first 21 months of service, 33 families, involving 116 children, were referred for protective service. While the service plan set 25 cases as the maximum caseload, the highest number carried in any one month has been 21 families (72 children).

Of the 72 children in these families, 18 from 9 families have gone into foster care, and, of these, 12 are expected to remain in long-term care. In two cases (five children), work with the family is now geared toward obtaining surrender of the children by the parent or parents.

Some Findings. While it was anticipated that the protective service worker would deal frequently with the family court, this has not been the case. Thus far, all the children who have had to be placed outside their own homes have been placed with the voluntary consent of their parents. This is due to the skill of the protective worker in interpreting to the families the need for the children's placement. However, it is recognized that an effective protective service requires a close relationship with family court, and it is expected that the court's authority will need to be invoked often in future cases.

Another anticipation that has not materialized is that most of the protective cases would be short-term cases, carried by the protective worker only until the acute crisis was resolved, then either closed or transferred to another unit of the department. The worker has in fact carried many cases over long periods of time. Three factors have been behind this: (1) while the worker's intervention has in many instances resolved the crisis, it has not eliminated the need for intensive service, and a change of workers has not seemed wise after a relationship has been established; (2) the worker's caseload has remained small enough for the non-acute cases to be retained without detriment to those still in a critical state; (3) the large caseloads in the Under Care Unit make it unrealistic to transfer cases there which still need intensive service. However, a number of cases have been transferred to the family counseling service.

While the protective caseload has built up gradually, it has burdened the worker with the special strains inherent in a service which is provided on an involuntary rather than a voluntary basis. A protective worker struggles constantly with the problem of evaluating the factors in the home which could be strengthened to preserve the home for the child, and those which are having negative effects upon the child. The constant focus in each case must be on the question of whether a meaningful home is being preserved for the child or whether a child is being allowed to remain in a damaging situation. This, of course, is an issue to some extent in all welfare services involving children. However, the protective worker carries a caseload in which that pressing question is the critical issue in every case and in which the clients are all involuntarily subjected to his services. Progress in such cases is slow, when it occurs at all.

The agency's experience has underscored the importance of supporting the protective worker with highly skilled supervision. It has also raised the question of whether it might not be desirable to vary the worker's caseload so that he could have some relief from the heavy strain involved in protective services.

Family Day Care

In June of 1964, the family day-care service was initiated by a newly assigned worker in the Home Services Unit. The worker's first assignment was the compilation of data pertinent to family day care, and the development of a statement describing the program as it would operate in Rensselaer County, including the types of situations appropriate for referral, the extent of service, rates for service, and referral procedures. The statement was used to acquaint the department staff and the staff of other community agencies with the program.

As soon as the program was announced, two families were referred for the service by family counseling workers, one by the local child guidance clinic, and two by the department's Public Assistance Division. After about 3 months, the Public Assistance Division was asked to review its entire caseload and estimate the number of children for whom family day care would be an appropriate service. The result was 75 children from this source alone.

Homefinding. Five months elapsed from the initiation of the program until the first child was placed in a family home for care during the day. Lack of experience with this kind of program led to a tendency to approach recruiting in the same manner as boarding home recruitment. It therefore reached a frustrating point in which a few homes were available and ready and a few children were waiting for the service, but, because of distance between the children's homes and the day-care homes, no service could be initiated. Eventually, however, the agency devised the more successful technique of recruiting for homes in specific areas for specific children known to need the service.

The family day-care worker had spent considerable time studying the homes of five women referred as possible day-care mothers by various units of the department. Two were approved, but they lived so far from the children for whom care was needed that the day-care placements could not be made. Therefore, an advertisement was run in the local newspaper for 3 days, outlining a specific area within the city in which homes were needed. A total of 21 responses was received.

The agency responded quickly to all inquiries received from the newspaper publicity. With the exception of three screened out in the first telephone contact, an appointment for a home visit within a week was made with each respondent. While this worked well, the agency decided to include in future newspaper recruiting advertisements a time and place for a group meeting rather than urging applicants to contact the office individually. This not only provided a natural screening process which eliminated persons with only superficial interest, but also an opportunity to explain the elements of the program to everyone at the same time.

Staff and Procedures

Programs cannot be broadened in any way unless competent staff are available to carry out the additional services. The fact that they have been available for the Rensselaer County home services project is due to the New York State Department of Social Welfare's long-established educational program for child welfare personnel. Under this program, qualified persons are provided with stipends for professional social work education in exchange for a commitment to work for a specified period in a public welfare agency within the State as assigned by the State department. The new trainees, therefore, have been designated as the State's source of the personnel

Homemaker service in action. This is 1 of 4 important child welfare services recently added to local welfare programs in a New York State county, as described in this article. The other 3: family counseling, protective services, family day care.

needed in its plan to help counties develop home services, and it was from this source that the four workers were secured to provide the protective, preventive, and family day-care services in the Rensselaer County project.

The coupling of the professional training program and the development of home services has heightened the value of the former and improved the quality of the latter. It has provided newly trained persons with the kind of challenging assignment most likely to develop a lasting personal commitment to the public welfare field.

Flexibility has had to be the keynote in the Home Services Unit's administrative policies. Early in the program it became clear that the counseling and protective services cannot be provided effectively if working hours are limited to the agency's regular hours. Parents have to be interviewed after their working hours, children after school. Therefore, both the protective and family counseling workers schedule one full evening a week for such interviews. On the day of their evening appointments, they are permitted to start work at noon. Compensatory time for overtime work is also allowed on other occasions when interviews must be scheduled outside regular hours.

In planning the worker's caseloads, distance and travel time are taken into consideration, since the service covers an entire county of 875 square miles.

The fact that the Children's Division has excellent intake personnel and procedures has been basic to the success of the project. When requests for counseling service or family day-care services come from outside the welfare department, the intake staff makes a thorough study of the situation before referring the case to the home services supervisor for assignment to a caseworker. When such requests come from the Public Assistance Division or another unit of the Children's Division, the intake worker discusses them with the supervisors of the referring units before acceptance for the service. Requests for homemaker service are referred by the Intake Unit directly to the home services supervisor for evaluation and assignment. Referrals, from any source, of cases seeming to require protective service are the subject of immediate consultation between the intake supervisor and the home services supervisor. The latter makes the casework assignment without any further investigation.

Coordination of Services

The presence of the Home Services Unit has brought about a noticeably closer working relationship between the Public Assistance Division and the Children's Division. Requests from the Public Assistance Division for service from the Children's Division in the year beginning August 1, 1963 (the period when most of the Home Services Unit's services got under way), were double those of the previous year. The existence of the Home Services Unit may have been only one factor in this increase, but it undoubtedly was a potent one.

Eleven of the first 18 family counseling cases and 11 of the first 25 protective service cases were carried cooperatively by the Home Services Unit and the Public Assistance Division, and the trend has continued. The work in these cases was characterized by close cooperation and frequent conferences. Conferences on public assistance cases in which homemakers have been used have also multiplied the contacts between the two divisions, as have the referrals for family day care. Thus, significant inroads have been made in the traditional attitude of coolness between these divisions.

In the past, a critical situation in a public assistance case often resulted in a request for placement of children on an emergency basis. Now, however, child welfare services are sought more often in relation to homemaker service, counseling, or protective services. There has been a noticeable reduction in requests for emergency placements.

In addition to providing a better quality of services, the work of the Home Services Unit has had the effect of teaching, by demonstration, some professional attitudes and approaches. The positive effect of this, while subtle, can be detected increasingly throughout the department in a pervasive attitude of service to the client and willingness to cooperate with others in the agency.

Effect on Foster Care

Placement of children away from their own homes has, of course, continued to be necessary in many cases. But in these cases the placements can be made with better planning because of the presence of a wider range of services.

While referrals to the division have nearly doubled since the beginning of the program, the placement of children in foster care has dropped sharply. From April 1, 1962, to March 31, 1963, the year immediately preceding the initiation of the new program, 593 children were referred to the Child Welfare Division, of whom 104 were referred to foster care. But from April 1, 1964, to March 31, 1965, the second full year of the program, 1,014 children were referred to the division, of whom only 79 went into foster care. As other services have been available, placement in foster care has become more of a specialty and, in practice, more treatment oriented. With this development, increasing emphasis is now being placed within the Under Care Unit on evaluating each foster care placement, whether boarding home or institution, to determine whether the child can return home, must remain in long-term foster care, or whether some permanent placement, such as adoption, can be made for him.

There are many ways to approach an evaluation of a program of services to children. The program might be considered from the standpoint of the number of children who have been enabled to remain in their own homes because of the availability of such services. It might be considered in relation to dollars saved by making placements in foster care unnecessary, or from the point of view of the less tangible human resources preserved. Another viewpoint could be the constructive effect of the addition of professional persons to agency staff. From any of these viewpoints, the implications of the Rensselaer County project seem clear.

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[1] Rutgers State University, University Extension Division: Cooperative project report: visiting homemaker service training course. New Brunswick, N.J. Revised Dec. 1, 1960.

Client, worker, and social scientist all have different views of . . .

THE PROBLEMS OF FAMILIES IN THE AFDC PROGRAM

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MRS. SMITH is the 42-year-old mother of 13 children. Born and reared in the Deep South, she migrated to the Detroit area in late adolescence in search of work during World War II. Despite only a fifth-grade education, she readily found employment during this period of labor shortage and continued to work in an unskilled job until after the war ended and she began having children.

Her children range in ages from 3 to 25. The first six were born when Mrs. Smith was married to a man whom she later divorced because of his drinking. A passing flirtation led to the birth of her seventh child. However, the last six children are all the children of the same father. This man, now no longer in the picture, has never contributed more than intermittently to the family's support.

Mrs. Smith receives the maximum allowance given in the Federal-State aid to families with dependent children program (AFDC) of the Michigan State Department of Social Welfare. This grant is supplemented by the general relief and surplus foods programs of the local welfare department. Nevertheless, Mrs. Smith still has a hard time making ends meet. The family lives in an old and crowded tenement building in need of repair, in a neighborhood where there is much crime and delinquency. The children are not always properly clothed or fed, and some of them are badly in need of medical or dental care. Often they do not have enough money for their school supplies and laboratory fees.

Poverty is obviously an omnipresent problem in the Smith family. But poverty in this family, as in many of the 9.3 million families in this country with incomes under $3,000, is a reflection of a complex of other problems. Some of these have been noted in a congressional report:

> A closer examination of the statistics regarding poverty shows the scars of discrimination, lack of education, and broken homes. Of the poor, 22 percent are nonwhite and nearly one-half of all nonwhites live in poverty. The heads of over 60 percent of all poor families have only a grade school education. . . .[1]

While sharing the complex problems of poverty with a host of other families, the Smith family experiences these problems in its own ways, and has its own strengths and weaknesses to help or impede its efforts to break out of the poverty chain. In addition to money, it needs services to tip the balance in favor of the strengths—services based on an understanding of the family's own perceptions of its problems and how these may be overcome, as well as on the perceptions of the experts.

In preparation for the development of a special service program for families in the AFDC program in Detroit, the University of Michigan School of Social Work has undertaken an exploration into the mothers' perceptions of their problems and how well these correspond with the views of the public welfare workers and social scientists. The undertaking is part of a project being carried out in the department by the school, with a Federal grant from the Children's Bureau, to demonstrate the utility of the social group-work method in a public welfare setting.[2]

This analysis is the responsibility of the authors, and not of the Michigan State Department of Social Welfare or its staff.

In this project, mothers in the AFDC program were invited to form discussion groups, each group to focus on one area, such as the mothers' employment opportunities, the adjustment problems of families with incapacitated fathers, child-rearing difficulties, and school problems. The groups met weekly for 6 to 12 sessions. Leaders, drawn from the agency's personnel and students of the School of Social Work, were closely supervised by an experienced social group worker.

We quickly learned that in order to provide an effective service, we need to know more about the families' problems and their origins—from the viewpoints of clients, workers, and social scientists. The following findings are based on preliminary data gathered during 1963–64 and a review of the literature. More complicated data, gathered in 1965, are now in the process of analysis.

The Clients' View

We constructed an open-end, probe-type questionnaire eliciting information about the immediate problems of applicants for and recipients of AFDC (hereafter called "clients") and their plans for solving them. Included were such questions as "What has worried you most during the past few weeks?" and "What have you been trying to do about this problem?" The questionnaire was administered to 16 applicants to the program after the completion of the regular intake interview. A similar questionnaire was administered during the same period to 17 mothers in the group sessions focused on the mothers' employment problems.

The problems mentioned by mothers in the two samples were similar, except that employment problems, as would be expected, were mentioned more often by those attending the group meetings.

As anticipated, many of the participating women described concrete problems. Fifty-eight percent of the problems mentioned involved the need for money, either in general or for specific purposes such as medical care or school clothes. This percentage included the 16 percent of the problems mentioned which were concerned with the mothers' own employment difficulties or those of their husbands, and the 13 percent that were concerned with poor living quarters or the necessity of living with relatives.

One-quarter of all the problems delineated had to do with children. (Some of these were also included in the 58 percent involving the need for money.) Among the specific difficulties mentioned were dressing children adequately for school, locating a good babysitter, and the effects on a child of living in a crowded home with quarreling relatives. In addition, a good deal of general anxiety about the children's future was expressed, especially in relation to the lack of a father in the home, the mother's inability to give children the things they needed or wanted, and fear of not being able to rear the children properly.

Somewhat less expected was the degree of concern about health—the focus of 19 percent of the problems mentioned. Many women expressed worry about specific conditions and the out-of-reach cost of needed medical or dental care. Some mentioned their own and their husband's inability to work because of ill health, and some expressed worry about having nobody to care for their children if they became ill. Four of the women said they had a "nervous" condition. Women whose husbands were incapacitated saw problems in the effect of the man's illness upon relationships within the family and in their own ability to accept the role of household head and breadwinner.

Few of the respondents said much about marital problems, possibly because of the shortness of the interviews. In general, when marital problems were mentioned they were expressed as hurt over divorce or desertion, hope for reconciliation (though the husband may have been gone for several years), or unhappiness over the actions of an estranged husband. One woman said flatly that if she could remarry, all her problems would be solved.

While much anxiety was expressed about specific areas of social functioning, almost one-fourth (23 percent) of the problems mentioned indicated the existence of a more or less generalized anxiety about the present or the future. Nevertheless, few respondents indicated having plans for alleviating their problems or any idea where they might get help with them. Even the few who said they had made plans or knew where they could get help expressed little hope of improvement. It may be that the client's very anxiety about her problems prevents her from doing anything about them. This is a hypothesis presently being tested.

In summary, our inquiry indicated, not unexpectedly, that the mothers involved saw the scarcity of money as their major problem. They apparently felt helpless about the situation they were in and knew of no way to get out of it. They revealed little awareness that a part of their problem might have been their own inability to call on the personal and situational resources at their disposal. How-

ever, they did show concern about the effects of their present circumstances on their children.

The Workers' View

Workers' perspectives are colored both by agency policy and the attitudes of the public at large. At times their views reflect the inconsistencies of both these frames of reference, particularly since the emphasis in the program is changing from income maintenance to rehabilitation.

In the study, the opinions of the agency's caseworkers and supervisors were sought in two staff meetings. The lists of problems turned in by the caseworkers, when recommending clients for participation in the social group-work meetings, constituted another source of information.

We found that the caseworker tends to see most clearly what the client sees least clearly: that in many instances the client's inadequacy in using her resources led to her present problems and are at least partially responsible for her inability to get out of the situation she is in. The caseworkers describe the clients as living from day to day, or even in the past, as if all their ambitions and hopes had ended with the crisis that led to the application for public assistance. Some are described as immature, emotionally unstable, alcoholic, or immoral; some as being pleasure-bent with little or no interest in their children, their homes, or employment. Others are described as tending to give their children excessive protection, but, paradoxically, seeming unaware that irresponsible behavior in other areas of life may also affect their children. Other problems mentioned were poor budgeting of funds, unwise buying, poor housekeeping, and carelessness in the physical care of children.

At the same time, the caseworkers recognized the fact that most of the women in the program have problems that are unrelated to their morals and values. They also recognized that those women with questionable values have never experienced, and do not now see evidence of, any other kind. They pointed out that many clients in seeking employment are handicapped by real problems, such as inadequate child care facilities, transportation difficulties, poor personal appearance, chronic ill health, and lack of education and skills. They pointed out that, for many clients, employment offers no real economic advantages unless it is steady and secure and the money earned is budgeted for an unmet need rather than deducted from the assistance grant.

The workers expressed particular concern for the children in the program, most of whom are living in broken homes. They mentioned the lack of appropriate opportunities for male identification for boys in fatherless homes. They expressed somewhat less concern about the psychological effects that divorce, desertion, or illegitimate pregnancy may have upon the mothers themselves or about their difficulties in trying to do a job generally carried out by two persons. However, they did point out that the women in the AFDC program are lonely women who have few social outlets. One caseworker suggested that society may be expecting higher moral standards of these women than are common in the general population. Many others expressed concern not only for the children in the program but also for their mothers, and gave evidence of wanting to help them.

Sociological Factors

From the sociological point of view, a mother who receives public aid is a deviant in several ways. She is a member of the lower class in a society where middle-class values predominate. She is supported by public funds in a society in which self-support is the tradition. Unless she is one of the mothers who is in the program because her husband is incapacitated, she is rearing children without a father present in a society whose acceptance of the broken home is much stronger in print than in actuality. She is apt to be poorly educated and may be of less than average intelligence. With all these strikes against her, she is expected to live on an income which is no more than minimal by any standards and less than minimal by many.

Social scientists point out that one of the strongest determinants of an individual's chances in life is his position in the class structure.[3] In a sense, social class defines the individual's responses to the major social pressures. Lacking the partial protection that money, power, or personal influence can give, the child born into a family poor in money, education, and skills is more vulnerable than others to the vicissitudes of life. His chances for getting a good education are poor for several reasons. He receives less than normal encouragement and enrichment in the home; and possibly also less than normal in school, for cultural deprivation may give an appearance of stupidity even to a bright child. In addition, the school system may be dominated by middle-class values to such an extent that neither the content nor methods of the teaching are effective with a child from a different background.[4, 5]

The poorly educated person finds few employment

opportunities open to him, and these decrease as technological advances eliminate more and more unskilled jobs. Such jobs as are open to him are the least desirable ones in terms of pay; job security; working conditions relevant to health and safety; and fringe benefits, such as insurance and sick leave. Frequent layoffs are likely, and savings to tide the family over a crisis are almost impossible to come by.

Having less access to adequate medical care throughout his life than most people, the person of low socioeconomic status is more prone to illness. Since his employment often requires physical labor, he can become incapacitated by a physical condition that would not be incapacitating to persons in more sedentary work. His poor education and lack of skills make him less adaptable to new occupations after an economic crisis.[6]

The income of the families in the AFDC program is at the lower limits of low incomes. Housing is, of necessity, usually in cheap rental units where the condition of the building may create problems in housekeeping and in efforts to make the home attractive. Drab and deteriorating housing, depressing both adults and children, often discourages women from any effort to improve their homes. Overcrowding in the homes of relatives, not uncommon in families in the AFDC program, not only requires greater physical effort in housekeeping but also creates problems in family relations.

Thus, economic need affects every part of daily life.

Receiving support from public funds is not an unmixed blessing. This is particularly true for the mothers in the AFDC program, a program long the target of much public disapproval. The uniform minimum standards of need limit to employment expenses and a few unbudgeted items of need the amount of any additional income they may receive without having their AFDC payments reduced. Thus, a mother cannot raise her family's economic level above minimal standards unless she is able to take on the entire burden of the family's support.

Psychological Factors

Among the most pervasive effects of social class status are the attitudes and values instilled in children. Not only are differences in opportunity perpetuated in each succeeding generation, but a style of life and a value system commensurate with the realities of the position are also perpetuated. Many studies have shown class differentials in child-rearing practices,[7] health practices,[8] living patterns,[9] and attitudes toward sex.[10] Current theories of child development indicate that such differences experienced as children will produce psychological differences in adults, differences which tend to maintain adults in the socioeconomic status of their childhood.

Rainwater, Coleman, and Handel have studied the attitudes of women of lower socioeconomic status.[11] Presumably, the AFDC clients are similar to these women, with two important exceptions: the AFDC recipients must live on an income considerably below that of the women these investigators studied; and most of the women in the AFDC program have gone through marital crises.

The women studied by Rainwater and associates regarded themselves as acted upon rather than acting. They saw the world as unchangeable. Such a woman responds only when she is approached in terms that are "specific, clearly defined, and readily understood". She feels helpless in the face of a chaotic world; she does not reach out to it. Seeing what happens in life as based on luck or fate rather than on her own actions, she has a "fairly pervasive anxiety over possible fundamental deprivations."

Such a woman does not lack hope, for luck may also be good, but she does not expect to be personally successful against forces she cannot control. Her gratifications tend to come from her own limited world of husband and children. She likes to be "needed." Yet, again, she does not see herself as having effective power over her husband, and little over her children after their babyhood. She greatly fears loneliness.[11]

What then must be the psychological state of the AFDC recipient who, divorced from or deserted by the father of her children, is in the midst of a crisis of the type most feared by women of low socio-economic status? Surely the sense of a chaotic world, of personal inadequacy, and of anxiety over future catastrophe must be increased.

One may assume that the dissolution of a family unit is a traumatic experience whatever the emotional relationship of the adults involved. Regardless of any other emotions, the very fact that the relationship has failed tends to lower the self-esteem of both husband and wife. Social disapproval often complicates the adjustment. A woman who has been deserted or divorced against her will might be expected to have a sharp sense of personal failure and inferiority as well as a good deal of bitterness, which may be turned either outward upon the former spouse or inward upon the self. When the woman has to depend upon public funds for support, the

sense of inadequacy may be aggravated and may in turn heighten the helpless and dependent attitudes fostered by the lifetime experiences encountered by persons of low socioeconomic status.

Mothers As Family Heads

The mother who has become head of the family through divorce, widowhood, or the incapacity of the husband is a focal point for many of the conflicts in the value system of society. Society's expectations of her, as well as her own, are apt to be confused and contradictory. A woman should work to support herself, rather than become dependent, but a mother should stay home and take care of her children. A woman should help her family in any way possible, but her role in marriage should be that of a dependent and relatively subordinate partner. A woman may work so long as her children are well cared for, but society is not obligated to help her arrange for the day care of her children. A woman alone must be strong enough to take over the paternal role of breadwinner and disciplinarian while maintaining her own role as housekeeper and mother; yet she must remain feminine enough to prevent her children from receiving a distorted conception of the feminine role in social relationships.

Women of low socioeconomic status who are heads of families face additional difficulties. Some have many children whose care leaves them little time for a companionable and educational relationship with them. However, such women are apt to look for gratification from their children in present affection rather than in future achievement.

Such women tend to be interested in broad categories of behavior such as "being good" and "being healthy," but to feel helpless about influencing the details of their children's behavior. When there is no father in the home, their tendency to protectiveness, rather than the fostering of development, becomes further exaggerated. Since the home is the source of the woman's satisfaction, the attention once given to the husband may be transferred to the children. The paradox of overprotectiveness and extreme permissiveness often found in the homes of women of low socioeconomic status may be due to the passive attitudes of the mother toward life in general and toward the children's behavior in particular.[11, 12, 13]

Women of low socioeconomic status are not joiners; the world must come to them. Such tendencies toward isolation intensify the loneliness of the female head of the household. A woman without a man is a proverbial fifth wheel in many social activities; yet a mother who goes out with a man must be extremely circumspect in her activities, particularly if she is a recipient of public aid, or the suitability of her home may be questioned. Even when the social activity is irreproachable, the problem remains of finding a babysitter she can afford.

In addition, mothers in the AFDC program who are raising their children alone face the same problems confronting any woman in this situation. How can they provide male identification for their children? What priorities must they set upon their time and energies? In short, how does one play two full-time roles concurrently?

The conflicts implicit in the social role of a mother in the AFDC program, and the contradictory and often ambiguous demands society makes upon the woman who is rearing children without a father in the home, are likely to create a paralyzing level of anxiety in the individual. Studies have indicated that persons subject to conflicting forces are likely to react not with "goal directed activity" but rather with "restlessness, a desire to leave the field, aggressive feelings toward himself and others and so on." [14]

Such a level of anxiety may become a problem in itself. It may be the source of the tendency to live in the present, and of the pleasure-bent behavior noted by the caseworker in our study. It may prevent clients from making greater use of the resources available to them.

The Practitioner's Problem

The views of the client, the social worker, and the social scientist overlap, although there are differences in emphasis both within and among groups. Nevertheless, all three groups have the same goals for the family in the AFDC program: financial independence and emotional security.

The problem the practitioner faces is to find a way to help the family to achieve these interlocking goals. The clients' complex, interrelated problems cannot be reduced to a simple cause-and-effect formula. All of the major factors seem to be both causes and effects, like "the chicken and the egg." However, the circular cause-effect relationship may well mean that changes accomplished by intervention in one area of life will in turn affect many other areas. Therefore, the practitioner needs an integrated view of the family, adding to his own observations the perspectives of the client and the social scientist.

With these perspectives, he will find that each family requires a somewhat different rehabilitation

plan. He may need to deal with pressing situational factors by helping parents and children secure the clothing, housing, and medical care necessary for maintaining the kind of standard in their daily living under which they can build the self-confidence required to help themselves in other ways. He may need to help parents and children to improve their education and skills by referring them to training or retraining programs or working with school personnel. He may also find need to deal, through referral or directly, with the many psychological factors impeding the family's solution of its problem. Some mothers may require counseling through groupwork and casework methods in order to change attitudes and values which are detrimental to themselves or to their children's development. Some may also need help in learning how best to carry out the dual role of mother and family head and in weathering the unusual stresses this entails. Some children may need special help with emotional problems.

This review suggests several foci requiring special attention. One is the problem of psychological passivity, which in so many families in the AFDC program not only inhibits efforts toward solving immediate problems, but also affects the quality of parental control over children and the quality of the self-image internalized by the children. Another is the need for helping families develop techniques of living in a manner acceptable to society and advantageous to the physical health and well-being of the family, techniques their past experiences have not given them an opportunity to develop. A third is the need for defining the appropriate role for lone parents and for recognizing the structural limitations as well as the psychological elements in the one-parent family.

Effective intervention at the individual or family level requires a framework of appropriate public social policy. It must be adequate to the need and involve a strategy that takes account of the complexity of the problem. Whatever the nature of the problem it attacks—sociological, psychological, or social-psychological—the problem areas are so interrelated that intervention in any one can affect the others if it is planned from an all-encompassing perspective.

The important thing is to build on the family's strengths, for, with the help of appropriate community resources, many families in the AFDC program have succeeded in improving their situation. For example, let's take another look at the Smith family:

Mrs. Smith gives her children the best physical care possible in her circumstances. Her oldest son is a college graduate and her two older daughters are presently in college. The family is closely knit. When told that he was not obligated to help his half-brothers and sisters, the oldest son said that he paid no attention to that: "They are my brothers and sisters and I will help them as much as I can."

Mrs. Smith has been a member of one of our mothers' groups focused on helping parents maximize the school experience for their children. She has contributed generously to the formation of more useful attitudes on the part of other group members while receiving a good deal of support for her own efforts.

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Some highlights from the National Conference on Day Care Services emphasize . . .

DAY CARE AS A SERVICE FOR ALL WHO NEED IT

KATHRYN CLOSE

A SENSE of urgency and a sense of hope permeated the meetings of the National Conference on Day Care Services, in Washington, D.C., May 13–15. Held under the auspices of the National Committee for the Day Care of Children, the Child Welfare League of America, and the Children's Bureau, the conference brought together more than 1,100 persons to discuss ways of stimulating appropriate day-care services for all children needing them. Its participants included administrators, board members, proprietors and consumers of day-care services, representatives of business and organized labor, and members of a variety of professional disciplines in the health, welfare, and educational fields.

They met in plenary sessions, general sessions of 3 subconference groups, and 24 work groups which on one day focused on specific topics and, on the next, on the problems of States, according to region, and of cities, according to size.

The sense of urgency came from the concern which prompted the conference—a realization that when children have unmet needs, time wasted before filling them can never be made up. The sense of hope derived from the repeatedly expressed feeling that the climate of the day was a fertile one for planting seeds of action.

"You are here at exactly the right moment," the conferees were told by the Vice President of the United States, Hubert H. Humphrey, and he suggested that they "join in the clamor" for the attention of Congress.

"The greatest deficit in America is not the fiscal deficit, but the human deficit," the Vice President said. Naming "the cost of crime, the cost of delinquency, the cost of hopelessness" as "the costs America ought to be concerned about," he suggested "spending a little extra" in programs that yield dividends—improved education, cultural activities, wholesome recreation, and public day-care centers.

Calling day care a "national necessity," particularly for children of working mothers, the Vice President pointed out that 86 percent of such mothers are working out of economic necessity—"the complaints against them come from somebody who doesn't have to work and doesn't understand the circumstances." But he also spoke of the need for day care for physically, mentally, or emotionally handicapped children, and particularly for children from poverty-stricken homes. "Day care is not a limited concept; it is not just for low-income families and working mothers. It is for the child who needs it, when and where he needs it, and for the length of time he needs it."

This was the concept of day care stressed throughout the conference. It was spelled out in the opening address by U.S. Commissioner of Welfare Ellen Winston as "the right of the child for adequate day-care services as a way of strengthening and preserving family life." And it was illustrated at the same banquet session by six consumers of day-care service—five mothers and a father who told what the service meant to them.

"I'm sure the strain on me was a strain on my children," said a young doctor's wife—mother of two hyperactive retarded children. She told of improvement in the children's behavior as well as her own sense of well-being since she placed them in a day-care center.

"I can now work in peace," said a mother of six children, who had turned to a day-care service in the housing project where she lived when her own mother, the children's previous caretaker, died.

Another mother of six said she lived on an isolated farm in the Kentucky mountains, far from other families and children. She gave a mission-housed day-care center the credit for the fact that her fifth child, now in school, "has outdone the four who went before him."

The Need

A spectrum of problems leads to the need for a spectrum of services in day care, Katherine B. Oettinger, Chief of the Children's Bureau, pointed out in another session, identifying some as "family breakup, changing family structures, unwed mothers, physical handicaps, mental retardation, emotional problems and mental illness, job mobility, cultural deprivation." And these, she said, are not limited to any one income group; nor are haphazard arrangements for the care of children in the mother's absence. Day-care service, she maintained, is more than "a holding action," for it provides the "social and emotional enrichment" that many children need.

Testimony to the inadequacy of day care today came throughout the conference. It was backed up by some stark figures. Speaking of the "attrition" in such services since the Lanham Act expired at the end of World War II, Mary Dublin Keyserling, Director of the Women's Bureau, U.S. Department of Labor, pointed out that while 5½ million more women are working today than at the peak of the war, "the licensed public and voluntary day-care facilities now available to our children provide for only about one-sixth of the number cared for as of July 1945." Chicago, she said, had 23 publicly supported day-care centers at that time and now has only one. Detroit, with 80 then, has none. Mrs. Keyserling predicted a 17-percent increase in the employment of women by 1970.

What this may mean to children was illustrated by some figures presented by Mrs. Oettinger from the preliminary findings of a survey made in February 1965 for the Children's Bureau and the Women's Bureau by the U.S. Bureau of the Census. (See p. 159.) Nearly a million children under 14 were estimated to be on their own during working hours, she reported.

What one speaker called "schizophrenic cultural attitudes" took the onus for the lag between need and services—the deeply ingrained feeling that mothers should stay at home with their children (unless they are threatened with public dependency) in a culture which depends on women workers for much of its prosperity. Joseph H. Reid, executive director of the Child Welfare League of America, told of findings of a study of attitudes made by the League which showed that many of the same people who said they did not believe in day-care services for children also disapproved of requiring standards for those day-care services which do exist.

Coordination

But Mr. Reid also suggested that research into the attitudes and standards of the professional people who are engaged in day care might reveal that differences of opinion among them about "what it is, who should be doing it, and what it should be composed of" constitute one of the chief barriers to advance.

Indirect evidence of such "administrative barriers" was provided in the frequent calls for coordination heard from the platform and in discussion groups—coordination in planning, in financing, in interpretation, and in the provision of services. These were directed not only to the fund-providing and standard-setting Federal and State agencies, but also to the professions which provide the health, education, and welfare components of day-care services and nursery schools. There was an obvious consensus that both types of services should be strong in all three components. As Julius B. Richmond, M.D., program director of the Office of Economic Opportunity's Project Head Start, expressed it, "the needs of the young child must be met comprehensively in order for him to thrive." He proposed the term "child development center" to place the emphasis on the child—"and by inference his family"—rather than on the institution.

The Family

The family-centered focus of day-care service and its nature as a supplement to family life were stressed again and again. Conferees told of "reaching out" to involve reluctant parents in day-care programs as learners, as observers, and even as participants. One said: "Our greatest gratification is when a child, becoming more relaxed and giving under our care, influences his parents, and they become more relaxed and giving." Another told of drawing unemployed fathers into the program's activities: "It gives them a sense of usefulness and they *are* interested in their children."

Repeated warnings were given, however, against expecting a day-care service to accomplish miracles in a social vacuum. In describing the deteriorating influence of poverty and discrimination on "millions of American families," James R. Dumpson, New York City Commissioner of Welfare, made it clear that more than day care is required for those whose lives are marked by "poor quality education, overcrowded dilapidated housing, poverty, poor physical and mental health, alienation from the larger community, humiliation and rejection based on ethnic considerations."

Between 5 and 6 million children live in one-parent families, Mr. Dumpson said, and Mrs. Keyserling pointed out that in 56 percent of the fatherless families in this country the mother is working, including 37 percent of those with children under 3. Supplementing family life for these children, a number of participants suggested, would mean drawing "male figures" into day-care programs as volunteers or staff assistants.

Manpower and Staff

Project Head Start received much attention at the conference—both as an opportunity and a threat. The Vice President referred to it as an "unprecedented assault on the deprivation of youth"—one "going so fast that the critics can't catch up with it"—a pace confirmed by Dr. Richmond's announcement that it would soon make grants to about 2,600 communities for over 10,000 preschool programs involving about a half million children. Nobody denied the opportunity this represented for children, but many a worry was expressed by directors of established services as to what this would mean in competition for qualified staff, especially preschool teachers. "We can't pay the salaries to compete," was a frequent comment, or "We already lose most of our teachers to the public school system as soon as they become certified." One participant remarked that the best way to get salaries up was through such competition.

Expansion of day-care services—the purpose of the conference—would depend on ingenuity in recruiting, training, and use of staff, it was generally agreed. "We must all be willing to change some of our preconceived ideas about *how* we train people," said John Neimeyer, president of the Bank Street College of Education. He suggested more training on the job, more intensive short-term courses, the provision of good supervision, and changing the traditional qualifications for trainees. Francis Keppel, U.S. Commissioner of Education, also proposed seeking new resources of teaching, citing an example of a day-care center in Oakland, Calif., where children received educational help from older students, mothers volunteering their time, and caseworkers assigned to the center.

Others saw nonprofessionals, whether paid or volunteer, as fitting almost anywhere in the program, but always under supervision. They saw sources of help in grandparents, teenagers, VISTA

volunteers, neighborhood mothers, and even "the old man who likes to whittle." High school graduates might be attracted to the program, it was suggested, if educational opportunities leading to careers were made available. They might be recruited, it was further suggested, if family life education courses used day-care centers as field placements.

Innovation and Protection

Innovation and a reexamination of principles to open long-stuck doors to children's opportunity were strong underlying themes of the conference, especially in relation to children for whom day-care services are all but lacking—infants and toddlers, school-age children, children of migrants and of military personnel, and handicapped children.

One work group spent some time discussing how many adults to a child a group care service for infants should contain—a type of service once regarded as unthinkable by standard-setting agencies. And, pointing out that the Children's Bureau is seeking solutions for the vast number of inadequately cared for children among the 1½ million children under 3 whose mothers are working, Mrs. Oettinger reported that the Bureau had modified its previous position of discouraging group care for such young children and was financing two research projects to determine effective ways to provide this kind of service.

But family day care was obviously still the method preferred by child welfare agencies for children under 3. The question was raised, however, as to whether this could expand enough to meet the need.

Family day care was also discussed as a possibility for school-age children—"by the time school is over the child may be tired of a group"—but after-school group programs, with emphasis on recreation, received the most attention. Both space and lack of community interest were mentioned as major problems in establishing services for this "forgotten day-care responsibility." Schoolhouses and grounds were identified as widespread, accessible, and, except in school hours, largely unused resources. Labeling such locked-up schools as "fortress schools," Dr. Keppel recommended replacing them "not with bricks and cement but with a new focus and a new spirit."

Group day care for children with handicaps—physical, mental, or emotional—was stressed as a grave need, not only for the sake of the social and cognitive development of the children, but also to relieve the strain on their heavily burdened mothers. Special day-care services—now rare—were called for as essential for the severely handicapped. At the same time, operators of regular day-care services were urged to open their doors to the less severely handicapped and to prepare their staff and facilities for their special needs. Parent counseling and flexible arrangements with community services were noted as especially important in services for the handicapped.

The culturally deprived child, noted as a special risk in regard to emotional, social, and cognitive development, was the target of the conferees' strong educational emphasis. Two speakers, Milton J. E. Senn, M.D., and Robert D. Hess, referred to recent research showing that the basic difficulty of children who fail in school is a deficit in language development. Dr. Senn said that this research—coupled with new knowledge about the preschool child's readiness, even in infancy, to absorb the skills prerequisite for learning to read, write, and compute—underscored the importance of the educational component in day-care centers. Dr. Hess, however, warned against putting too much faith in experience enrichment and stimulation as such, and told of research which indicates that what the child with a language deficit needs is not merely to learn "new words" but to be shown "how ideas and events are related to one another."

Two work groups called for the waiv-

CHILD CARE ARRANGEMENTS OF WORKING MOTHERS

About 1 million children under 14 years of age whose mothers were employed in 1964—including 38,000 children under 6—were expected to care for themselves while their mothers were at work. These children represented 8 percent of the 12.3 million children under 14 whose mothers worked either full time or part time for 27 weeks or more in 1964. Approximately 6.1 million mothers of at least one child under 14 were so employed. Of their children, 3.8 million were under 6 years of age, of whom 1.6 million were under 3.

These are some of the preliminary findings of a survey sponsored by the Children's Bureau and the U.S. Department of Labor, Women's Bureau, and carried out in February 1965 by the Bureau of the Census, using its national sample of households. Besides a total lack of arrangements for 8 percent of the children, the survey revealed a variety of child care arrangements:

- Forty-six percent of the children were cared for in their own homes, by a father (15 percent), another relative (21 percent, including 5 percent by a relative under 16 years of age), or by a nonrelative (10 percent).
- Thirteen percent were looked after by their mothers while at work.
- Two percent were cared for in group care, such as day-care centers or after-school centers—4 percent of the children under 3 years of age, 7 percent of those 3 to 5 years old, and 1 percent of those 6 to 11.

The mothers of 15 percent of the children worked only while the children were in school.

Data on income revealed that the children lived in families with a wide range of income, an almost equal number—2 million—belonging to families having under $3,000 a year and to families having over $10,000 a year.

The preliminary findings of the survey were released by the two sponsoring Bureaus in mid-May in a publication, "Child Care Arrangements of the Nation's Working Mothers, 1965: A Preliminary Report," prepared for the National Conference on Day Care Services. A final report will be issued after all data have been received from the Bureau of the Census.

ing of State residence laws which prevent children from receiving services, especially children of migrant agricultural workers and children of military personnel. The waiving of State laws prohibiting the group care of migrant children under 3 was also urged.

Side by side with the conference's accent on innovation was a strong recognition of the importance of standards and of licensing in upholding and improving the quality of day-care service, whether offered on a commercial or a nonprofit basis. Standards were defined as the "ideal" in day care, and licensing as a way of working toward this and so protecting "children, their parents, the operators of services, and the community." "Standards always have to be a little out of reach," said one operator, "so we will have something to work toward."

"Double standards" in licensing were especially decried as confusing and unfair, and by this term was meant both the exemption of services under public and religious auspices and the differences in standards required of preschool services designated as "welfare" and those designated as "education." Correction, it was recognized, would involve change in State laws.

Much misunderstanding of standards could be eliminated, it was suggested, if operators and other community representatives were involved in their development. Flexibility in the use of authority was suggested as a means of using licensing as a method for bringing about improvement; but one participant—a licensed operator—saw "too much flexibility" as holding the danger of weakening strong laws.

Finances and Politics

Where and how to get funds? This double-headed question, holding the key to both expansion and improvement in day-care services, ran like a strong cord throughout the conference.

The answers to *where* leaned heavily on the Federal Government, with State and local resources—public and voluntary—recognized in a somewhat less hopeful way.

Present sources of Federal funds were pictured as promising "seed money," but confusing in their variety and differences in requirement. For example, money obtained through Project Head Start or the community action programs of the Office of Economic Opportunity could be secured with as little as 10 percent "matching" funds from State or local sources, while funds obtained through the Children's Bureau, extremely limited in the first place, after January 1, 1966, could be had only through a real 50–50 matching from the State. Recommendations for eliminating this matching requirement were many; and the conferees applauded loudly when Senator Abraham A. Ribicoff of Connecticut announced that a "child care package" which he plans to introduce to the Social Security Amendments of 1965 would do away with this matching requirement, raise the total of child welfare funds authorized, and require each State child welfare services plan to include day care by 1967.

A promise for eliminating some of the administrative confusions in the Federal day-care and preschool education picture came when Mrs. Oettinger told of a Children's Bureau plan to convene a small group, representative of Federal agencies interested in day care and early child development, to prepare a statement to serve as a "united base and common language" from which these agencies might operate.

The answers to the *how* part of the where-and-how question were many, but added up to two related forms of action: community mobilization and political action.

Here again, a "united front" was suggested, especially in localities where voluntary agencies reportedly have a hard time persuading United Funds of the importance of adequate salaries in upholding the quality of day care; and where unconvinced city councilmen and State legislators may impede the flow of any public money into the program. Leo Perlis, director of the AFL–CIO Community Service Activities, and W. O. Heinze, president of the International Latex Corporation, both spoke of the importance of involving business and labor in fund raising *and* planning because of their stake in seeing that good day-care services are available. Day-care councils were proposed to plan, to interpret, to lobby.

Strong plugs for lobbying on the national level were put in by Vice President Humphrey—"The Congress are here to listen to you. . . . Go up to Capitol Hill and lobby your heads off"—and by Senator Ribicoff, who departed from his prepared speech to give the conferees a practical lesson in how to approach a Senator or Congressman. Said the Senator: "Next time you come to Washington, send a letter ahead to your Senators and your Congressmen. Sit down and talk to them face to face when you get here, and then you will really have a chance to influence legislation."

Back to Work

In summarizing the subject work groups at the final session of the conference, Mrs. Randolph Guggenheimer brought out their stress on coordination; the need for increased Federal funds; parent participation; community interpretation; better salaries; inservice and professional training; broadened representation on agency boards; the use of volunteers and other types of auxiliary personnel; and the formation of day-care councils or local affiliates of the National Committee for the Day Care of Children.

Leonard Mayo, president of the International Union for Child Welfare and chairman of the conference, summarized the State- and city-focused work groups, bringing out their requests—

- *to the Federal Government* for more clarification of policies; more data, guidelines and consultation on standards and service operations, including up-to-date cost analysis figures; funds for construction of facilities; an open-end appropriation for child welfare;
- *to the States* for area meetings to review State standards and legislation; the strengthening of State advisory committees through broadened representation; review and strengthening of State licensing laws;
- *to localities* for basing the purchase of day care by public agencies on actual costs; and establishing central recruiting and training programs for day-care personnel.

Then Mr. Mayo turned to the question of *how*, and he too put a heavy accent on political know-how and action. After giving a seven-point "Mayo's law" for approaching councilmen, State legislators, and Congressmen, he said:

"We can go to work with the knowledge that no other country in the world has a political setup so responsive to what people want."

BOOK NOTES

THE CASE FOR THE WORKING MOTHER. Dorothy Whyte Cotton. Stein & Day, New York. 1965. 185 pp. $4.95.

In this book, the new editor-in-chief of *Parents' Magazine* examines the case for (and also against) the working mother, from the standpoints of how mothers can handle this dual responsibility; the effect on husband, children, other relatives, neighbors; the problems of babysitters, mother substitutes, nursery schools, day-care centers, after-school facilities; and how to get back into the labor market.

Pointing out that one out of every three mothers who have children under 18 are holding paying jobs, the author maintains that there is a need for society to come to grips with the "quiet revolution" in the employment of mothers outside the home. She cites numerous "case histories" of working mothers—not all of them success stories—and gives special attention to ways to insure proper care of children of various ages during the periods when their mothers are absent from the home.

CHILD HEALTH: Its Origins and Promotion. Edited by F. W. Clements and B. P. McCloskey. Edward Arnold, Ltd., London. (U.S. agents: Williams & Wilkins, Baltimore.) 1964. 402 pp. $5.75.

Originally conceived as a tool for imparting knowledge about child health to Australian teachers in training, this book, written by representatives from the fields of medicine, public health, and psychology—most of them Australians—is also recommended by the authors for students of nursing, medicine, and social work. Its emphasis is on health as a positive state rather than as the antithesis of illness. The editors are, respectively, Senior Lecturer, Child Health, University of Sydney, and Assistant Chief Health Officer (Child Health), Department of Health, Melbourne.

The collection is divided into the following five categories: "Human Change and Stability;" "Normal Growth and Development in a Western Society;" "Health and Well-Being;" "The Child and Disease;" and "Education for Health."

DIRECTORY FOR EXCEPTIONAL CHILDREN. Compiled and published by Porter Sargent, 11 Beacon Street, Boston, Mass. Fifth edition. 1965. 702 pp. $7.

Included in the more than 3,000 U.S. facilities—schools, hospitals, clinics, and others—for physically, mentally, or emotionally handicapped children described in this fifth edition of a directory first published in 1954 are 136 new programs and 300 programs, not previously listed, offering help for youth. About 100 facilities are noted as having closed or merged with other programs since 1958.

The new edition reveals a continuance of the trend toward nonresident day programs for exceptional children. Day schools and clinics now comprise two-thirds of the Nation's facilities for crippled children; 6 times more day centers than resident facilities have been established for physically handicapped youth since 1953; and, of the 136 new programs described in the book, nearly 50 are day offerings for mentally retarded children.

The directory reveals a 25-percent increase of programs of vocational training. More than 130 of the facilities described offer vocational training (apart from occupational therapy given by many more); 30 of these have been established since publication of the last edition of the directory in 1962.

MOTHERS OF SIX CULTURES: antecedents of child rearing. L. Minturn and W. W. Lambert. John Wiley & Sons, New York. 1964. 351 pp. $7.25.

Using interview techniques and the statistical method of factor analysis, the research reported in this book identifies factors or dimensions by which differences and similarities in child-rearing practices may be described among mothers who live in such diverse cultural settings as India, Okinawa, Mexico, Kenya, the Philippines, and the United States. Among the dimensions of child rearing found by statistical analysis were those dealing with maternal responsibility for the child, maternal warmth, and style of reaction against childhood aggression. A considerable part of the book is devoted to describing the child-rearing practices of mothers of each of the six cultures.

This study differs from most investigations of child-rearing practices in that its emphasis, instead of focusing on the effects of child-rearing practices on subsequent behavior of the child, is concerned with the antecedent conditions existing in the social and economic structure which may influence the pattern of the mother's child-rearing practices. For example, mothers living in a culture in which they are expected to participate in the economic maintenance of a family are likely to impose greater responsibility requirements on their children than mothers in a culture requiring little participation of this type from mothers.

VISION OF CHILDREN: an optometric symposium. Edited by Monroe J. Hirsch and Ralph E. Wick. Chilton Books, Philadelphia, Pa. 1963. 434 pp. $17.50.

The contributions to this symposium represent a wide range of subjects related to children's vision. Visual aspects of growth and development are discussed, with emphasis on prevention of visual disability. The contributors are almost all practicing and teaching optometrists.

Chapters with a large volume of theoretical and practical technical information, not assembled elsewhere, include: Weymouth's "Visual Acuity," Hirsch's "Refraction of Children," Morgan's "Anomalies of Binocular Vision," and Heath's "Color Vision."

Several chapters, with a more limited appeal, deal with practical aspects of clinical management, while other chapters are directed to the optometrist in the role of parent's adviser.

Summaries of ocular pathology and special educational considerations for the visually handicapped child are also included.

The demographic considerations that stimulate optometry to concern itself with children are discussed in Hofstetter's introductory chapter "Optometry and Children's Vision."

HERE AND THERE

Education Act

On April 11, 1965, the President signed the Elementary and Secondary Education Act of 1965, "to strengthen and improve educational quality and educational opportunities in the Nation's elementary and secondary schools."

The act's five substantive titles authorize the channeling through the Commissioner of Education of approximately $1.3 billion in Federal funds into education in this country.

Title I provides for a 3-year program of grants through State departments of education to local school districts containing concentrations of children from low-income families. The money is to be used for programs and projects (including the acquisition of equipment and construction of facilities) designed to meet the special needs of disadvantaged children. Arrangements such as educational television and radio, mobile educational equipment, and "dual enrollment" (permitting children in private schools to take courses in public schools) must be made to include the disadvantaged children attending nonpublic schools.

The grants to the States under Title I are to be based on a formula which takes into account average annual per-pupil expenditure and number of school-age children from "low-income families"—defined for 1966 as families with incomes under $2,000 per year or receiving more than $2,000 from the program of aid to families with dependent children. The Office of Education, U.S. Department of Health, Education, and Welfare, has estimated that this could amount to $1.06 billion for the fiscal year 1966.

Title II, carrying a specific authorization of $100 million for fiscal 1966, provides for a 5-year program of grants to State departments of education to make available, to children and teachers of both public and nonpublic schools, library resources, textbooks, and other published instructional material, the title to which would remain vested in a public agency. The States are required to develop policies to assure that the Federal funds are not used to supplant money that in their absence would be used to purchase such materials.

Title III, with a $100 million authorization for fiscal year 1966, establishes a 5-year program of grants to the States for supplementary educational centers and services to enrich the programs of elementary and secondary schools. Among other activities and services specifically mentioned are: special instruction in science, languages, music, and the arts; vocational guidance and counseling services; health and social services; remedial instruction; special programs during periods schools are not regularly in session; services for isolated rural areas; and the employment of specially qualified personnel, including artists and musicians.

Title IV extends the cooperative research program under which the Commissioner of Education makes direct grants for educational research and adds provisions for training research personnel and the construction and operation of research facilities. An appropriation of $45 million is being requested for research and training for fiscal 1966; for construction, a total of $100 million over a 5-year period.

Title V, with a $25 million authorization for 1966, initiates a 5-year program to stimulate and assist in strengthening the leadership resources of State educational agencies.

Mental Retardation

A possible link between mental retardation and toxoplasmosis has been reported by a team whose research, in the United States and Sau Salvador, is being carried on cooperatively by the Stanford (Calif.) University School of Medicine and the Palo Alto (Calif.) Medical Research Foundation. Toxoplasmosis, an infectious disease usually passed into the fetus by the mother, is frequently unrecognized clinically because many infants afflicted with it look normal at birth. Only 1 of 1,000 babies born in the United States has recognizable symptoms of toxoplasmosis, the team found, the total number of babies born with the disease being unknown.

Dr. Jack S. Remington summarized the team's findings at the First Annual Colloquium of the Lt. Joseph P. Kennedy, Jr., Laboratories for Molecular Medicine at Stanford last April. Babies born with the disease, he said, may become mentally retarded within the first 3 to 4 years of life. It is not known how an infected mother passes the organism to the child.

Dr. Remington said the evidence that the infection may be related to mental retardation was gathered in a study recently made at the Sonoma (Calif.) State Hospital. Blood tests performed on 350 children whose records showed their retardation to be of unknown origin produced evidence of significant amounts of toxoplasma antibodies in 11 percent of the children. Tests on another 400 children, selected after their cases had been studied to rule out toxoplasma infection as a cause of their retardation, showed only 3 percent to be positive. A serologic survey conducted in Palo Alto showed that, among 600 women of childbearing age, 29 percent had the toxoplasma parasite. Similar tests conducted in San Salvador proved positive for 60 percent of the women in the same age group.

Volunteers

In the 3 years since the establishment of a volunteer service program in the Children's Division of the Cook County (Ill.) Department of Public Aid, volunteers have rendered 3,021 hours of direct or indirect service to the 4,250 foster children under the legal guardianship of the department. Initiated in December 1962 with a grant from the Chicago Community Trust, the program at present includes 60 volunteers on active status and 51 on a list of prospective volunteers.

The volunteers work as assistants in home finding, child welfare aides, clerical aides, education aides, special program aides, and vocational tour escorts. The home-finding assistants handle telephone inquiries, do a preliminary screening of foster parent applicants,

mail recruitment literature, assist in group meetings for applicants, help to maintain inventories of foster homes, and keep the license renewal roster current. The child welfare aides help caseworkers in placing children; visit foster homes to complete questionnaires; and escort children to clinics and on shopping trips. Clerical aides furnish stenographic and secretarial services, gather data for research reports, and assist in manning the division's reception desk. Educational aides tutor children who are in foster care. Special program aides take children to ball games, the theater and the circus, and help in the camp program. Vocational tour escorts take teenagers on career tours to industrial establishments.

Working under the supervision of a full-time professional person, the volunteers serve either 1 day a week or a minimum of 8 hours a month for at least 6 months. All volunteers are required to complete a 2-day orientation course focused on the department's services. In addition, they receive inservice training on their specific job assignments.

. . .

A project to use teenagers as volunteers in services for children in the summer months, undertaken by the Division of Family and Child Welfare, Westchester County (N.Y.) Department of Public Welfare, proved so successful in the summer of 1964 that the agency is again carrying out a similar project in the summer of 1965.

Of the 60 young people who applied last summer, as a result of newspaper ads, 37 actually became volunteers and, of these, 31 carried out their assignments for the entire 12 weeks of the project. Except for a few who preferred, or were deemed more suited to, clerical assignments, the young people provided direct service to a total of 30 children—between the ages of 6 and 12—23 of them children in the child welfare services program and 7 in the public assistance program. Five of the six volunteers who did not continue through the 12 weeks were in clerical assignments.

All 60 applicants were screened in 45-minute interviews with the supervising caseworker in which their motives for volunteering were examined, their impressions of what children from a different background would be like explored, and their reactions to the responsibilities that would be expected of them and indications of their own personal stability observed.

Orientation consisted of two group meetings with the supervisor of the project, at which the needs of the children selected for service were explained and the importance of confidentiality discussed. At a third meeting, held at the halfway point in the project, the volunteers discussed their experiences with children. All but one of the children had been responsive to his volunteer.

The volunteers were under the supervision of a professional caseworker assigned on a full-time basis to the teenage project. Each prepared a written report on his experiences with the child assigned to him. Activities included trips to amusement parks, to the city, to the zoo; helping a child take out library cards; reading, storytelling, and visiting with a child; going for walks and window shopping. The children selected by the agency to receive the volunteers' services were in the main shy children, children from large families, and physically handicapped children. Aggressive children were not included in the project.

The majority of the volunteers came from middle or upper middle class families. Two, however, were in the public welfare caseload, one as a foster child and the other in the AFDC program.

Against Delinquency

Five former leaders of San Francisco street gangs are to be employed and given on-the-job training in a San Francisco juvenile delinquency control program which is part of a demonstration project supported by a Federal grant of $15,648 made through the Office of Juvenile Delinquency and Youth Development. The project is being carried out by the Institute for Social Science Research of San Francisco State College.

The ex-gang leaders, as detached workers for the Youth for Service Agency in San Francisco, will establish contact with street gangs and work with them informally in their own hangouts. The institute is proceeding on the theory that these ex-gang leaders have insights into youth problems, and rapport with youth, which the presently employed professionals do not have, and that their experiences as youth workers can be used to develop improved materials for training other youth workers.

Other grants for short-term demonstration projects approved since the first of the year under the Juvenile Delinquency and Youth Offenses Control Act of 1961 include:

- $53,276 to the Salt River Pima-Maricopa Community Council, Scottsdale, Ariz., to establish a community-sponsored and community-staffed youth center for delinquent boys and their parents on the Salt River Indian Reservation. The center, which will be administered by the tribal council, will also provide services to nondelinquent boys.
- $67,040 to the Oregon State Board of Control (MacLaren School for Boys), Salem, Oreg., to establish a combined halfway house, vocational training program, and job placement program for "nonschool oriented" boys being returned to the community from a State training school for delinquents.
- $125,290 to the Welfare Federation of Newark, N.J., to establish a short-term, educationally based, group-rehabilitation program for 14- and 15-year-old boys presenting both behavior and scholastic problems.
- $99,551 to the Kentucky Child Welfare Research Foundation, Inc., Frankfort, Ky., to help a junior-high-school-based, community-operated center in Louisville to operate a remedial program for "hard-core 13½- to 15½-year-old male offenders" combining work, education, and casework therapy.
- $31,656 to the Institute for Behavioral Research, Inc., Silver Spring, Md., for a project called CASE (Contingencies Applicable to Special Education) which will develop "new groupings" of subject matter and schedules and reinforcement techniques designed to increase the educational performances of selected boys from the National Training School for Boys, Washington, D.C. This project will be carried through with the cooperation of the Federal Bureau of Prisons.

Accidents

In 1964, accidents, the Nation's leading killer of youth, caused approximately 104,000 deaths—an increase of 3,000 over 1963—according to estimates of the Division of Accident Prevention, U.S. Public Health Service. The Division estimates that about 50 million persons in the United States yearly suffer accidental injuries which either restrict normal activity for a day or more, or

require medical attention, costing the Nation an estimated annual $15 billion.

Of the two broad categories on which the accidental death estimate is based, "motor vehicle" and "nonmotor vehicle," all of the increase was within the motor vehicle category. Motor vehicle accidental deaths reached a new high of 48,000 in 1964, 5,000 higher than in 1963.

In 1963, the latest year for which age-specific figures are available, the leading causes of accidental deaths among children were: children under 1 (total deaths, 3,500), mechanical suffocation, ingestion of food or foreign objects, and motor vehicles; age 1 to 4 (total 5,100), motor vehicles, fire, and drowning; age 5 to 14 (total 7,000), motor vehicles, drowning, and fires; and age 15 to 24 (total 15,900), motor vehicles, drowning, and firearms. In the 15- to 24-age bracket, accidents cause more deaths than all other causes combined.

. . .

Evidence of an urgent need for establishment of master regional poison control centers, to improve the work and services performed by the Nation's 540 poison control centers, has prompted the Public Health Service to initiate a 1-year research project to study the feasibility of the area poison control concept. The project will be carried out by the Metropolitan Denver Research Foundation, Inc., research arm of the Denver General Hospital. The PHS's Division of Accident Prevention plans to establish such centers in several regions of the country. According to information reported to the Division, approximately 500,000 children in the United States annually ingest poisons in liquid or solid form, and some 2,000 persons in all age groups die annually from such ingestion.

Child Welfare Research

Awards amounting to $404,021 were announced in mid-April by the Children's Bureau for 10 special studies to be undertaken, or continued, under the child welfare research and demonstration grants program.

Three of the grants, totaling $164,560 were for new research projects in child welfare:

• $72,762 to the Yale University Child Study Center, New Haven, Conn., for a program to study the differences in the developmental process in children from infancy to age 7 in three settings: group residences, foster families, and the children's own homes. The study will focus on the characteristics of the children's development and the relation of the setting to the children's developmental and behavior problems and to the processes of the children's adaptation to their physical, social, and psychological environment.

• $50,000 to the Council on Social Work Education, New York City, to develop curricula in social work education related to the welfare of children and the services required by them. Primary goals of this project are the identification of the knowledge required by all professional social workers about the needs of children and the services to provide for them, and the determination of specific additional knowledge and skills required by graduates of schools of social work entering the field of child welfare.

• $41,798 to Pacific Oaks College, Pasadena, Calif., for an observational study of day-care programs. This study's goal is to find out how the development of children is affected by different types of group day-care programs.

Seven continuing research and demonstration grants in child welfare were awarded, totaling $239,461: four of them ($103,789) for research projects and three ($135,672) for demonstration projects.

Child Development

Differences in the effects of certain types of maternal and child behavior on the intellectual development of boys and of girls are indicated in a recently completed analysis of data from the Berkeley Growth Study, a longitudinal study conducted by the Institute of Child Development, University of California at Berkeley, of children born in 1928 and 1929 as healthy newborns.

The analysis was carried out by two of the study's investigators, who are now with the National Institutes of Health. It revealed changing relationships between types of maternal and child behavior and children's intelligence over the 18-year span of the study, with shifts occurring with the children's changing age but differing according to sex.

For example, the sons of hostile mothers scored high in intelligence in the first year or so, but had low IQ's from 4 through 18. The sons of loving mothers were highly intelligent—growing from happy, inactive, and slow babies into friendly, intellectually alert boys and well-adjusted, extraverted adolescents. Daughters of loving, controlling mothers were happy, responsive babies who earned high mental scores. However, after 3 years the girls' intelligence scores showed little relation to either maternal or child behavior variables. Their childhood IQ's correlated primarily with the education of the parents and estimates of the mother's IQ.

These differences, with other findings on sex differences, led to a hypothesis of genetic sex differences. The impact of the environment (maternal behavior) on infant boys appeared to be persistent, both their behavior patterns and their intellectual functioning tending to become fixed by the 3d year and to persist at least through their 18th year; while girls' intellectual functioning appeared to be more genetically determined, as though the girls continually readjust their behavior to changing environmental conditions. The girls' intelligence seemed to be independent of those aspects of maternal and child behavior which were evidently important for the boys.

The report of the analysis, "Correlations of Maternal and Child Behaviors with the Development of Mental Abilities: Data from the Berkeley Growth Study," has been issued as volume 29, number 6, of *Monographs*, published by the Society for Research in Child Development.

Miscellaneous

"Breakthrough," a new recruitment play on public welfare social work careers, designed to interest high school and college students, had its premiere performance on May 25 at the annual forum of the National Conference on Social Welfare, Atlantic City, N.J. It was produced for the Welfare Administration, U.S. Department of Health, Education, and Welfare, by Plays for Living, a division of the Family Service Association of America.

. . .

The Office of Education has awarded more than $1.1 million to 75 colleges and universities to train teachers of children with serious speech or hearing defects in the academic year 1965–66. The money will be used to provide fellowships and to meet part of the cost of training new teachers.

IN THE JOURNALS

Role of the Father

John Nash, in the March 1965 issue of the quarterly *Child Development*, concludes that the relative neglect of the father in studies of our Western matricentric society "may have distorted our understanding of the dynamics of development in the rearing of males." ("The Father in Contemporary Culture and Current Psychological Literature.")

The author examines possible historical and social reasons for matricentric orientation, reviews the evidence on the effects of this orientation on the psychological development of boys, and presents some hypotheses about the father's role in child rearing, including—

- In Western society, the father, sole support of the family, relegates child rearing to his wife while he works to support the family.
- Clinical studies and investigations of delinquents suggest that father-child relationships, especially between father and son, may be significant in the development of both social and psychological abnormality.
- Psychosexual difficulties apparently result when a child's major identification is with the parent of the opposite sex.

Well Baby Care

Parents must be taught that the best way to learn how to take care of a baby is to observe the baby, according to Dr. Corbett H. Turner, of Emory University, Atlanta, Ga., writing in the May 1965 issue of *The Journal of Pediatrics*. ("An Approach Toward Well Baby Care During the First Months.") Therefore, the author maintains, parent counseling during the first months of an infant's life should aim at helping parents learn *from the infant*.

Dr. Turner cites several points in support of the approach he recommends:

- Mothers are not generally taught to feel that their observations of the baby are important, an attitude which often leads the mother into behavior contrary to her inclinations. She may, for example, when trying to learn how to take care of her baby, "spend most of her time looking at Dr. Spock instead of at the infant."
- If, for any reason, a mother feels herself to be inadequate in nurturing, she will almost invariably seek someone to tell her what to do. When she turns to the pediatrician, to whom parents "characteristically look," this may result in excessive telephoning, a resentful pediatrician, disgruntled parents, and unsatisfactory care of the infant.
- Satisfactory care depends on fitting it to the characteristics and needs of the individual infant; and parents, particularly the mother, have the opportunity to learn what these are, while the pediatrician usually does not.

Dr. Turner recommends that the mother can develop a nurturing *modus operandi* of (1) observing her baby and (2) basing her decision on what he needs.

Dentistry for the Handicapped

Drs. Wesley O. Young and John R. Mink, writing in the April 1965 issue of *Rehabilitation Literature*, conclude that "there is reason to believe that many handicapped children do not now receive the oral health care needed for total rehabilitation." ("Dental Care of the Handicapped Child.")

Some children are handicapped primarily by the conditions of their mouths, such as those with disfiguring deviations from normal occlusion. Still others—children with cerebral palsy, for example—may not have special dental problems, but have disabilities making it difficult to provide dental care for them unless special facilities, and dentists with special training, are available. Special treatment (including, on occasion, sedation or anesthesia, partial or general) may be required for mentally retarded children and for children with paraplegia, quadriplegia, multiple sclerosis, muscular dystrophy, congenital heart lesions, rheumatic fever damage, and disabilities due to poliomyelitis.

Noting that nearly 6,000 children are born each year in the United States with oral clefts, this affliction is discussed as a dental problem, as are neoplasms of the mouth and face, injuries and burns resulting in disfiguration and loss of function, and congenitally missing teeth.

According to the authors, 23 State crippled children's agencies offer dental treatment to children with cerebral palsy, 16 to mentally retarded children, 18 to children with other severe defects. Some handicapped children can obtain care from dental schools, hospital outpatient departments, and special clinics maintained by voluntary agencies such as State and local affiliates of the National Society for Crippled Children and Adults.

"Nevertheless," the authors conclude, "many severely handicapped children probably do not receive regular dental care, particularly those living outside of metropolitan centers."

School for Disturbed Children

A description of the education program in a children's psychiatric unit of a British hospital is given by the teacher-in-charge, Kay Vaughan, in the June 1965 issue of *Mental Health*, published by the British National Association for Mental Health. ("School on a Children's Psychiatric Unit.")

At the hospital in Southern England, two units for emotionally disturbed children, each with 15 beds, are operated by the Department of Child Psychiatry. The children include those with acute anxiety, aggressive tendencies, autism and high distractibility caused by brain damage.

Schooling in the units is provided under the hospital's policy that it is important in the process of getting well—and as a steppingstone to a return to outside school, particularly for "school phobics" who may have refused to attend school for a long time.

Diagnosis, testing, and remedial treatment continue at the units along with the schooling.

A few of the children are in school all day, but most are taught for only a part of the day, their disorders preventing them from being able to cope with full-time school.

In addition to learning what they can absorb of the three R's, the children

carry out a number of creative activities—preparing a guidebook on the sights of the city, getting out a newspaper, holding art shows, acting in playlets, forming clubs.

"Success," writes Miss Vaughan, "is measured by each child's achievement, according to his ability and mental health at the time."

Helper Therapy

Noting that "an age-old therapeutic approach is the use of people with a problem to help other people who have the same problem in more severe form"—as in Synanon (for drug addicts), Recovery Incorporated (for psychologically disturbed people), and Alcoholics Anonymous—Dr. Frank Riessman, associate professor, department of psychiatry, Albert Einstein College of Medicine, writing in the April 1965 issue of *Social Work*, states that "perhaps social work's strategy ought to be to devise ways of creating more helpers." ("The 'Helper' Therapy Principle.")

Dr. Riessman suggests that social work should seek to find ways to transform recipients of help into dispensers of help, thus reversing their roles; and that, in the development of this technique, helping situations should be structured, where possible, so that the recipients will be placed in roles requiring the giving of assistance.

He refers to current use of this principle in schools, mentioning specifically an experiment in Flint, Mich.

Noting that one of the best ways to learn is to teach, Dr. Riessman points out that the principle could have wide application in hospital groups, prisons, correctional institutions, and so on. He calls for "conscious planning" toward structuring groups for the widest possible distribution of the helper role.

Juvenile Court Judges

Following a survey of the more than 3,000 men and women who perform the function of juvenile court judges in the United States, part time or full time, Shirley D. McCune and Daniel L. Skoler, writing in the April 1965 issue of the quarterly, *Crime and Delinquency*, concluded that "it is a judiciary not adequately compensated" and that it exhibits "striking internal variations" which seem to follow the size of the jurisdiction—i.e., the population served—with the least favorable conditions existing in the smaller or rural courts. ("Juvenile Court Judges in the United States—Part I: A National Profile.")

The authors report that their survey was based on completed questionnaires received from judges in all 50 States, the District of Columbia, and Puerto Rico.

Mean annual income for the total group was found to be $12,490, with rural judges (serving populations of 20,000 or less) averaging $6,056 and metropolitan judges (populations of over 200,000) averaging nearly three times as much—$19,220.

"What stands out," the investigators wrote, "is that juvenile court judges as a group remain underpaid, both as judges and as members of the legal profession."

As to staff resources, 33 percent of the full-time juvenile court judges indicated that they had no probation officers or social workers—in rural courts, the comparable figure was 54 percent. Eighty-three percent reported that they did not have any psychologists or psychiatrists.

As to key problems, the judges in large jurisdictions indicated the most pressing to be the lack of foster home placement facilities, the need for improved correctional facilities and for additional probation services. Judges in small jurisdictions stressed the need for detention and shelter care facilities, the insufficiency of foster home facilities, and the need for "more knowledge about the right way to handle cases."

Guides and Reports

DAY CARE: AN EXPANDING RESOURCE FOR CHILDREN. Child Welfare League of America, 44 East 23d Street, New York, 10010. 1965. 75 pp. $1.50.

The nine papers in this monograph focus on ways to expand day-care programs as (1) a protective service for children and (2) a preventive service for their parents.

PERSPECTIVES ON ADOPTION RESEARCH. Introduction by Henry S. Maas. Child Welfare League of America, 44 East 23d Street, New York, 10010. 1965. 64 pp. $1.50. Includes four papers exploring the current status of adoption research and areas for future study, theoretical issues and approaches, methodological needs, and the value of adoption studies to the practitioner.

PUBLIC SCHOOL CLASSES FOR THE EMOTIONALLY HANDICAPPED: A Research Analysis. William C. Morse, Richard L. Cutler, and Albert H. Fink. The Council for Exceptional Children, National Education Association, 1201 16th Street NW., Washington, D.C., 20036. November 1964. 142 pp. $2.50.

A nationwide study of 117 special classes for emotionally handicapped children, which concludes that although "the programs are doing some good . . . the research reveals an amazing lack of specific pattern and uniformity in approach."

PROCEEDINGS: INTERNATIONAL COPENHAGEN CONGRESS ON THE SCIENTIFIC STUDY OF MENTAL RETARDATION (Vols. 1 and 2). Edited by Jakob Øster with the assistance of Henning V. Sletved. Statens Åndssvageforsorg Falkoner Allé 1, Copenhagen, F. Denmark. 1965. 895 pp. $5.

Included are the 159 papers presented at the congress in Copenhagen, August 7–14, 1964, sponsored by the International Association for the Scientific Study of Mental Deficiency. They report research on the genetic, medical, psychological, educational, and social aspects of mental retardation.

READERS' EXCHANGE

Memories of Frances Perkins Secretary of Labor, 1933–1945

KATHARINE F. LENROOT

Former Chief of the Children's Bureau

I FIRST met Frances Perkins as Grace Abbott and I, and thousands of others, were walking down Pennsylvania Avenue in Washington, D.C., on our return from President Roosevelt's first inaugural. As a member of the incoming Cabinet she was on her way to luncheon at the White House, but her automobile was stalled in the traffic. Seeing this, we stopped to chat with her for a few moments. Like all the others in this great throng, we had just been greatly stirred by the new President's call to conquer fear—"the only thing we have to fear is fear itself." On this rather slight and feminine person rested a large share of responsibility for helping him to give leadership in removing as far as possible the burdens of uncertainty and anxiety carried by all the people and of extreme deprivation borne by the unemployed and their families.

In writing of those days in March 1933, Miss Perkins spoke of the two great terrors that had to be faced—unemployment and the money crisis. "We had," she said, "to work out a plan of cooperation between natural economic laws and social needs." ("People at Work," by Frances Perkins, John Day Co., New York, 1934.)

The "conference method"—bringing together representatives of all interested groups—she adopted as one of the principal techniques of the Department of Labor for achieving its objectives. To her part in the task she brought both a New England conscience and true Yankee realism; a living faith in God and in the potentialities and inherent good will of most men and women; a belief in the processes of democracy; sympathetic understanding of and concern for people; a liberal education with advanced study and a wealth of practical experience; keen intelligence; love of beauty; a sense of humor; unswerving courage; and firm loyalty to those she served, the colleagues with whom she worked, and the friends she cherished. These qualities armed her for leadership and participation during 12 years of depression, struggle for recovery, and war.

Among my most cherished memories are the pre-Christmas assemblies of the entire Department of Labor staff in Washington, which she led with reading of the Gospel story and a simple Christmas message which came from her heart.

She built a strong Department of Labor from one which, in some of its aspects, was feebly equipped in legal authority, direction, and personnel. This she did with a minimum of bureaucratic overhead and formalism, and a maximum of direct personal relationship with the people on its staff.

Occupied as she was with the critical problems of economic and industrial life and management-labor relations, she gave unfailing support to efforts to provide greater protection and opportunities for children and young people. Provisions in their interest were included in many of the major pieces of legislation which she helped to mold and for which she carried either complete or collaborative responsibility for implementing. She always had time for the concerns of the Children's Bureau and devoted many hours to leadership in its conferences and meetings, especially in the 1940 White House Conference on Children in a Democracy.

When it was understood in January 1945 that she had decided, for personal reasons, to ask President Roosevelt to accept her resignation, our hearts sank. Then, one day, on return from the White House, she called in the Department's officials and told us how concerned she was over the weariness of the President, and how she had been unable to say "no" to him when he pressed her to continue in office.

In the foreword to the "Papers and Discussions at the Initial Session of the White House Conference on Children in a Democracy," Miss Perkins wrote:

"Democracy is not only a form of government, it is not only a matter of people living in liberty with each other; there is involved in it the experience of men in liking each other, in getting on together, and in using the friendship so generated to develop a better life and a better relationship for all the people who come after us. We need to take these things for granted in America and go on to see what more we can do with them in behalf of the children of the next generation."

BRIELAND: ***Another team experiment***

As the administrator of a large public child welfare agency which is faced with a serious shortage of professionally prepared social workers, I found Donald Brieland's article, "The Efficient Use of Child Welfare Personnel," to be of unusual interest. [CHILDREN, May–June 1965.]

Dr. Brieland's description of experiments employing a team approach to discharge specific child welfare functions promises several kinds of manpower gains. It offers possibilities of conserving the time of fully trained child welfare personnel by assigning specific functions to lesser trained persons. This approach might open the door to extensive and effective use of subprofessionals. Still another gain might be scored by giving more workers stimulation and support as functioning members of a team rather than in isolated solo performance.

Dr. Brieland's article provides encouragement for the prospective joint project of the Kent School of Social Work (University of Louisville) and the Kentucky State Department of Child Welfare. The project would involve the development of training teams or units, captained by jointly appointed supervisors and made up of a graduate student or two, one or two child welfare workers without professional social work training, and a senior undergraduate drawn from the social work sequence of the University of Kentucky.

This would be a service team which would undertake all child welfare functions in the community in which it was located, as part of a carefully designed training program.

The need which Dr. Brieland describes, and the kind of teaching materials which might be more effective in training subprofessionals, will strike a responsive chord in all who carry some responsibility for preservice and inservice training programs in public agencies.

Richard J. Clendenen
Commissioner, Kentucky State Department of Child Welfare

RE FOSTER PARENTS: *Ideas wanted*

We would like to share ideas with other children's agencies concerning ways and means of recruiting, training, and retaining good foster parents.

Our agency has a foster parents' *Newsletter*, published 3 times a year for approximately 500 foster parents. This includes general agency announcements, interpretative articles about child care, and articles written by foster parents themselves. Also, we enlist the foster parents' help in recruiting additional foster parents and give recognition for this in the *Newsletter*. We see this organ as another aid in bringing the foster parents closer to the agency and to an understanding of their important role in our program.

In the 9 years that the *Newsletter* has been published, we have only been able to locate three other agencies with a similar publication. We are sure there are more and would like to exchange issues with them.

However, the *Newsletter* is only one of several methods our agency uses to help foster parents develop their skills in their job of caring for children. In addition to providing them with the regular supervision of a caseworker, the agency holds group meetings for foster parents, led by our staff development leader. Some are round-table discussions attended by 8 to 10 foster-parent couples, who themselves pick the subjects for discussion. Others are general meetings attended by all the foster parents and are focused on such topics as: "Foster Families, Foster Children's Families, and Social Workers;" "The Why and How of Discipline;" "Rivalry Among Sisters, Brothers, and Foster Children;" "Why Children Ask About Sex."

The women's auxiliary of our board gives an annual recognition party for foster parents, which is a gala affair.

We would like to know what other agencies are doing to improve the supply and quality of boarding homes for children. If any would like to participate in an exchange of ideas, we hope they will communicate with us.

Doris A. Lawler
Assistant Director, Services for Children, Child Welfare Board of Summit County, Akron, Ohio

DENNIS: *It can be done*

Public welfare workers have become increasingly concerned over the fragmentary nature of the various medical services sought out by their clients. The medical services paid for by the agency are generally limited in scope and duration, and the payments are all too often less than the usual charges. Welfare medicine has been described as *symptomatic* medical care, dealing with the obvious partial effects while ignoring the underlying totality of causes. The client is treated by the physician or at the clinic for a virus infection or severe cold, while his developing arteriosclerosis goes unheeded for lack of complete examination.

It is therefore encouraging to read of the active, aggressive interest and participation of a community hospital in raising not only the tone and quality but also the long-range effectiveness of medical care for public welfare clients, as described by Margaret A. Dennis in "Improving Coordination of Welfare and Medical Services" (CHILDREN, May–June 1965). Studies in Pennsylvania and elsewhere have shown that medical problems represent the greatest single barrier in helping public assistance recipients achieve self-support or self-care.

Public assistance recipients in particular need *comprehensive* medical care, including complete examination and identification of medical problems, and early treatment to forestall the necessity for the more complex and costly medical services that are the fruit of neglect. The New York Hospital Welfare-Medical Care Project is providing such care. Similar projects are under consideration in Pennsylvania, at the Montefiore Hospital in Pittsburgh and at Temple University Hospital in Philadelphia. The New York Hospital project has shown what can be done and how, but, above all, *that it can be done.*

A comprehensive, hospital-based system of medical care for public welfare clients will undoubtedly raise pointed questions. If assistance recipients are assigned to a hospital for all their necessary medical services, what becomes of the individual's so-called "freedom of choice" of health practitioner? Should public welfare clients be treated differently from others who need medical care? What about the neighborhood physician who will lose a source of income when some, perhaps many, of his patients are assigned to the hospital-based program?

Other, more basic questions may also be asked. Are traditional methods of delivering and paying for medical services the only or the most effective methods in a public medical program for dependent persons? What will be the role of the hospital in the medical care of the future? It is to the credit of the New York Hospital Welfare-Medical Care Project that it was not deterred by these questions.

Can welfare recipients be provided good-quality medical care, in one place, by the same body of practitioners who know his medical and social problems and needs? Can workers in welfare and medical fields learn to operate cooperatively, recognizing that their client, with multifaceted problems, is nonetheless *one* person? The New York project has answered these questions affirmatively.

William B. Tollen
Commissioner of Public Assistance, Pennsylvania State Department of Public Welfare

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U.S. GOVERNMENT PRINTING OFFICE: 1965

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

THE CLOSED, SHORT-TERM GROUP: A Treatment Adjunct for Parents of Mentally Retarded Children. Helen L. Beck. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1965. 11 pp. Single copies available from the Bureau without charge.

A discussion of the methods, goals, and effectiveness of working with closed, short-term groups of parents to help them deal with problems confronting them as parents of mentally retarded children.

CONFERENCE PROCEEDINGS: THE EXTENSION OF LEGAL SERVICES TO THE POOR. November 12–14, 1964. Washington, D.C. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. 1965. 202 pp. 60 cents.

A report on the first nationwide conference called under Federal auspices to explore the possibilities for cooperation between lawyers and social workers to assure adequate and more effective legal services for the poor. (See "Rights of the Poor," CHILDREN, January–February 1965, p. 36.)

The texts of addresses by the Commissioner of Welfare, the Attorney General of the United States, and of all panel presentations are included, together with introductions and summaries of discussions following each panel.

HISTORICAL PERSPECTIVE ON MENTAL RETARDATION DURING THE DECADE 1954–1964; a compilation of articles in CHILDREN. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 426. 1964. 314 pp. $1.75.

This publication presents 60 articles published in CHILDREN between 1954–64 on developments in meeting the problems of mental retardation in children and on related services in maternal and child health and crippled children's programs. It begins with a presentation of the then known causes of mental retardation and ends with a discussion of prospective developments under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963. Also included are a foreword by the Chief of the Children's Bureau and a history of the Bureau's mental retardation activities.

JUVENILE DELINQUENCY SERVICES. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 421. 1964. 48 pp. 25 cents.

Addressed to citizens and community leaders, this illustrated pamphlet explains the roles of various community agents and services in preventing juvenile delinquency and rehabilitating the youthful offender. It stresses the responsibility of citizen action to see that the community provides the appropriate resources.

THE CHILD WITH A SPEECH PROBLEM. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Folder No. 52. 1964. 24 pp. 15 cents.

This pamphlet offers suggestions to parents for helping a child to improve his speech and for recognizing problems requiring the services of specialists. It discusses the emotional and physical origins of various types of speech disorders and the availability of professional facilities for proper treatment.

CHILDREN is published by the Children's Bureau six times a year. Use of funds for printing this publication was approved by the Director of the Bureau of the Budget, September 21, 1962.

NOTE TO AUTHORS: Manuscripts are considered for publication only if they have not been previously published. Speeches from conferences should carry appropriate identification. Opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the views of CHILDREN or of the Children's Bureau.

Communications regarding editorial matters should be addressed to:

CHILDREN
Children's Bureau
U.S. Department of Health, Education, and Welfare
Washington, D.C., 20201.

Subscribers should remit directly to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

CHILDREN is regularly indexed by the Education Index and the Nursing Literature Index

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C., 1965

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.
Price 25 cents a copy. Annual subscription price $1.25
50 cents additional for foreign subscriptions

UNIVERSITY MICROFILMS INC
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DIVISION OF PUBLIC DOCUMENTS
WASHINGTON D.C. 20402

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Published 6 times annually by the

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